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ABSTRACT

This assessment of Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for children, based on a 2-year survey of national data and a study of EPSDT programs in five states (Michigan, Mississippi, New Jersey, New York and South Carolina), documents inadequate health resources for low-income children and their families. The study of five state programs, focusing on one county in each state, included examination of available data, visits to study sites and talks with a wide range of program personnel. Major aims of the study were to determine (1) to what extent EPSDT is providing poor children with adequate health care, (2) what improvements are needed, and (3) what the implications of EPSDT are for designing a national health insurance program. The document presents the background of the Medicaid program and its EPSDT component, which requires the provision of EPSDT services to all children (under 21) eligible for Medicaid. Questions of administration and enforcement are examined, and detailed findings and recommendations are presented on: outreach needs and methods; screening, diagnosis and treatment; developmental assessment; and ways of linking children to an ongoing source of primary health care. The report finds that too few of the program's intended recipients are being adequately served. Recommendations are presented for changes in EPSDT and for a national health insurance program to eventually supersede it. (BF)

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EPSDT

Does It Spell Health Care For Poor Children?

A Report by the

CHILDREN'S DEFENSE FUND

of the Washington Research Project, Inc.

PS009422

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PHOTO CREDITS

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COVER

The painting for the cover of this report was done by artist Ellen Roff, who lives in Brooklyn, New York.

Preface

EPSDT is a group of letters whose meaning is often lost to policymakers and the general public. But as this country's single largest federal program providing health care for poor children, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program of 1967 is significant. For millions of American youngsters living in families too poor to pay for checkups, visits to the doctor, routine tests and pediatric care, EPSDT's services offer the only hope of preventive or primary health care.

For this reason, EPSDT interested the Children's Defense Fund from the start. We monitored its progress as the federal government and the states dragged their feet in implementing it. In 1971, after years of fruitless negotiations, the National Welfare Rights Organization asked for our help in suing HEW for its failure to issue regulations so the program could be enforced. The suit eventually was filed. Regulations were issued later that year.

But regulations were only the beginning. Myriad questions continued to be raised about whether services were reaching children, whether states should act more quickly to provide those services, and whether HEW should move more vigorously to carry out Congress' intent. CDF continued to monitor these activities and to press for making promised services available to children.

Meanwhile, we were shaping our broader agenda in the area of child health. After considering the wide range of health needs children and their families had and where our energies could have the most impact, we decided to concentrate our activities on *primary* health care for children, and we set about pulling together the literature and defining the principles that would profile our program.

Those principles were spelled out in our first health report, *Doctors and Dollars Are Not Enough*, issued in May, 1976. In it we cited the evidence supporting our standards for good health care, and we gave examples of programs around the country that were delivering good health services to children and families, incorporating these principles.

Following the release of *Doctors and Dollars Are Not Enough*, we looked at EPSDT to see how this preventive and primary health care program was measuring up to our criteria of quality services. Once the initial period of pushing to get the program off the ground was over, we decided it was time to look at whether and how the program was helping the children it was designed to serve. Thus, we planned a small-scale study and collected and analyzed the data that are the basis for this report.

Our work on *Doctors and Dollars Are Not Enough* and *EPSDT* has made crystal clear to us that children and families in America will not have adequate or equitable health care until a comprehensive national health program is enacted. This is our principal goal.

Why then are we attempting to patch up the existing system by recommending reforms in EPSDT? Our answer is simple: Poor children are entitled to health care right now. They have only one childhood and it should not be riddled with unnecessary and preventable health problems. Their needs cannot wait the years it will take to get the needed comprehensive health system in place.

We issue this report at a time when there is a good deal of skepticism about large government programs and cries to cut back federal spending. But our research on EPSDT has shown again that short-run economies in the health care field lead to long-run inflationary spirals in health care costs for services that do not meet families' health needs. Our research has shown further that without federal support for and strong leadership in delivering health care, it is not the providers or the industries supporting them that will suffer, it is the children. They simply go without health care and their conditions get worse with time. We must insist that the goals of a stable economy and a balanced budget not be attained at the expense of our children.

The Carter Administration has taken an important step forward to improve EPSDT by sending to Congress on April 25, 1977 its legislative proposal called CHAP, the Child Health Assessment Program. We hope our findings and recommendations will be considered seriously in the further development of the CHAP program. We urge those who care about children's health and well-being to join us to seek improvements--not as the panacea for all the health needs of poor children but rather as a necessary, immediate step until we succeed in getting national health insurance to cover all Americans.

I would like to thank CDF's health staff, particularly Wendy Lazarus, for the insights, judgment and prodigious amount of work necessary to produce this report and to bring our findings to the attention of those who can and must make changes to improve children's health services.

Marian Wright Edelman
Director

Acknowledgments

Our deep respect and thanks go to Mike Trister who was the first among us to understand EPSDT's vast potential. His initial leadership and persistent belief in the value of looking at EPSDT prompted us to undertake this study.

Donna Brown was indispensable in helping carry out the field work, in drafting sections of this report and in reviewing subsequent versions. Her incisiveness and ability to separate the important from the unimportant were particularly valuable as we waded through the complexities of Medicaid.

In addition to her work on many parts of this report, Judy Weitz thought through one of the most controversial and difficult aspects of the program--the area of developmental assessment. She brought enthusiasm and creativity to this report from the beginning, and her dedication lasted up to and including the day she gave birth to her son, Thomas.

Warmest thanks to Rochelle Beck for transforming the first draft into the final report. Her patience and skill in eliciting what we wanted to say were combined with a unique ability to say it best.

Sally Makacynas and Marilyn Rash spent long hours getting this report ready to go to the printer. Their high standards and willingness to work hard enough to meet them were directly responsible for the quality of the finished product.

Special thanks to the many people who gave us their insights about EPSDT reform and who consulted with us about our recommendations. Our deep appreciation, too, to the people who spent considerable time reviewing the early draft and provided us with extremely useful comments. We wish to thank Jack Anderson, Judy Kellogg Barber, Pat Butler, Brad Caftel, Anne-Marie Foltz, Rashi Fein, Robert Haggerty, Bill Schuetz, Barney Sellars, Earl Siegel, Mike Trister and our colleagues at the Children's Defense Fund. For her continuing support and her vision in relating facts, figures and findings to fundamental

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We are extremely appreciative of the people in our study sites who made time to talk with us and who shared their insights so openly.

Finally, we are grateful to the Foundation for Child Development in New York for its generous support of our work.

Wendy Lazarus

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Introduction

Medicaid and EPSDT: What You Need To Know About How They Work

For readers who do not already have a working knowledge of the Medicaid and EPSDT laws and programs, we have included here a brief summary of their major features.

Medicaid

What Is It?

Medicaid is the name used to describe the medical assistance program legislated by Title XIX of the Social Security Act. Passed by Congress in 1965, Medicaid pays the bills for the health care of low-income and/or disabled families and individuals in America. Medicaid does not attempt to alter the way health care is delivered, nor to assure that services are available, accessible or provided. Rather, it reimburses providers for the care they give to poor people so that poverty is not a barrier to receiving needed health care.

Medicaid is a federal-state program; that is, the states (and in some cases localities) and the federal government share the costs. It is administered by each state within broad federal requirements and guidelines. Beyond certain federal stipulations in the statute and regulations, states determine what benefits are covered, who is eligible, what the rates of payment to providers are, who can provide covered services and how the program is administered.

Who Is It For?

Figuring out who is eligible for Medicaid benefits is one of the most complicated aspects of the program. Basically, Medicaid pays for medical care for people who are receiving cash payments under public assistance programs established by the Social Security Act:

(1) Title IV-A, Aid to Families With Dependent Children (AFDC), which makes payments to members of families with dependent children where one parent is absent, incapaci-

tated or unemployed; and

(2) Title XVI, Supplemental Security Income (SSI), which makes payments to individuals who are aged, blind or disabled.

Eligibility for benefits under one of these programs automatically means eligibility for Medicaid. This group of beneficiaries is called the *"categorically needy."*

States may include other groups as eligible for Medicaid. For example, states may include members of poor families where an unemployed father is living at home, even if those states do not cover these families for cash assistance.

Another optional group is the *"medically needy"*--those people who meet all the requirements of AFDC or SSI but whose income is higher than the level for eligibility set by the state before their income is adjusted for medical expenses. If their income would qualify them for cash assistance after medical expenses were accounted for, then they could qualify as medically needy, if states choose to include that category in Medicaid.

States can also cover *"financially needy"* children, that is, children under 21 whose families meet state financial eligibility standards but not one of the categorical requirements. (Categorical requirements include being a member of a family with dependent children where one parent is absent, incapacitated or unemployed or being an individual who is aged, blind or disabled.) This allows, for example, children in intact families with little income to qualify for Medicaid. Rather than covering all such children, states can choose to cover subgroups of financially needy children, such as those in foster care or in psychiatric hospitals.[1] (For a list of which groups each state covers in its Medicaid program, see Table 1.)

In addition to income and categorical requirements, eligibility for Medicaid also depends on being a resident of the state, although states cannot require any minimum period of residency. Every person needs to be certified eligible for Medicaid and get a Medicaid card to take to a provider in order to get services through the Medicaid program.

What Services Are Covered?

Federal law mandates that Medicaid programs *must* cover certain specific services: inpatient hospital services; outpatient hospital services; physician services; laboratory and X-ray services; skilled nursing-home health services for individuals over 21 years of age and some health services for persons who are in nursing homes; early and periodic screening, diagnosis and treatment for individuals under 21 years of age; and family planning services.[2] Even for these mandatory services, states may limit coverage, provided that the amount, duration and scope are "sufficient...to reasonably achieve their purposes."[3] States must also assure that needed transportation to and from necessary medical care is available either by arranging for it through an agency or with volunteers, or by paying for it or providing it directly.[4]

---

[1] Under 42 U.S.C. §1396d(a)(i) of the Medicaid law (one of the so-called Ribicoff Amendments), states are given the option of covering individuals under the age of 21 who are "financially eligible." That is, eligibility may be extended to children who do not qualify as dependent children under a state's AFDC plan, but whose families meet the state-defined income standards for assistance. The implementing regulation (45 C.F.R. §248.1(c)(iv)) allows states to limit such optional coverage to "groups of such individuals if based on reasonable classifications."

Each state has the *option* of covering other services and receiving federal reimbursement: clinic services; prescribed drugs; dental services; prosthetic devices; eyeglasses; medical supplies; private duty nursing; physical therapy; optometrist services; podiatrist services; chiropractor services; psychiatric hospital services for persons under 21; mental or tuberculosis hospital services for patients over 65; and any other medical or remedial care recognized under state law.[5] States can limit the amount and/or duration of each of these services (for example, set a maximum number of outpatient visits a person is entitled to per month). They can require prior authorization in order for the provider to get reimbursement for certain services (for example, establish the need before paying for outpatient psychiatric services). And states can require Medicaid recipients to share the cost of certain medical expenses (for example, $.50 on a drug prescription).[6] (For a list of services covered by Medicaid by state, see Table 2.)

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[2] 42 U.S.C. §1396d(a)(1)-(5).

[3] 45 C.F.R. §249.10(a)(5).

[4] 45 C.F.R. §249.10(a)(5)(iii).

[5] 42 U.S.C. §1396d(a)(6)-(17).

[6] The law states that no cost-sharing can be imposed on mandatory services for cash assistance recipients, but states can impose "nominal" cost-sharing requirements on optional services for cash assistance recipients, and on all services for the medically needy.

For a more detailed analysis of these provisions see: U.S. House of Representatives, Committee on Interstate and Foreign Commerce, "Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966-1976," (Washington, D.C.: U.S. Government Printing Office, 1976); and Patricia A. Butler, "The Medicaid Program: Current Statutory Requirements and Judicial Interpretations," *Clearinghouse Review* (May 1974), pp. 15-16.

Table 1

BASIC MEDICAID ELIGIBILITY COVERAGE, BY STATE

STATE	"CATEGORICALLY NEEDY"			"MEDICALLY NEEDY"	"UNEMPLOYED FATHERS"		"FINANCIALLY NEEDY"				
	AFDC	SSI									
		All	Restricted *		and their families	only their children	all financially needy children under 21	children under 21 in foster care*	children under 21 in psychiatric hospitals	children under 21 in intermediate care facilities	other reasonable classifications
ALABAMA	■	■						■			
ALASKA	■	■						■		■	
ARIZONA											
ARKANSAS	■	■		■			■				
CALIFORNIA	■	■		■	■	■	■				
COLORADO	■		■		■	■		■	■	■	
CONNECTICUT	■		■	■		■	■				
DELAWARE	■	■			■	■		■			
D.C.	■	■		■	■	■	■				
FLORIDA	■	■						■			
GEORGIA	■	■									
GUAM	■			■	■	■					
HAWAII	■		■	■	■	■		■		■	■
IDAHO	■	■						■		■	
ILLINOIS	■		■	■	■	■		■			
INDIANA	■		■						■		
IOWA	■	■			■	■		■			
KANSAS	■	■		■	■	■		■	■	■	■
KENTUCKY	■	■		■		■		■	■		■
LOUISIANA	■	■						■	■	■	
MAINE	■	■		■		■	■				
MARYLAND	■	■		■	■	■	■				

MASSACHUSETTS	■	■		■	■	■	■				
MICHIGAN	■	■		■	■	■	■				
MINNESOTA	■		■	■	■	■	■				
MISSISSIPPI	■		■					■			
MISSOURI	■		■		■	■		■			
MONTANA	■	■		■				■	■	■	
NEBRASKA	■		■	■	■	■		■			■
NEVADA	■	■						■			■
NEW HAMPSHIRE	■		■	■				■			
NEW JERSEY	■	■					■				
NEW MEXICO	■	■						■		■	
NEW YORK	■	■		■	■	■	■				
NORTH CAROLINA	■		■	■				■			■
NORTH DAKOTA	■	■		■				■	■	■	
OHIO	■		■		■	■					
OKLAHOMA	■		■	■	■	■	■				
OREGON	■	■			■	■		■	■	■	■
PENNSYLVANIA	■	■		■	■	■	■				
PUERTO RICO	■			■		■					
RHODE ISLAND	■	■		■	■	■		■			
SOUTH CAROLINA	■	■						■			
SOUTH DAKOTA	■	■						■			
TENNESSEE	■	■		■				■	■		
TEXAS	■	■						■			
UTAH	■		■	■	■	■	■				
VERMONT	■	■		■	■	■	■				
VIRGIN ISLANDS	■			■		■					
VIRGINIA	■	■		■				■		■	
WASHINGTON	■	■		■	■	■					
WEST VIRGINIA	■	■		■	■	■		■			
WISCONSIN	■	■		■	■	■	■				
WYOMING	■	■									
TOTAL	53	36	14	32	26	31	16	20	9	11	7

1) States have the option of limiting Medicaid coverage of SSI recipients by requiring that such recipients meet any more restrictive eligibility standards which were in effect in a state on January 1, 1972, prior to the implementation of the SSI Program. States exercising this option, however, are required to provide for a "spend-down" for all aged, blind, and disabled persons (not just SSI recipients) by deducting any medical expenses incurred from income in determining Medicaid eligibility.

2) For whom public agencies assume financial responsibility.

Source: Medical Services Administration, Social Rehabilitation Services, HEW, March 1975 and October 1976.

Table 2

MEDICAID SERVICES STATE BY STATE,

JUNE 1, 1976[1/]

*BASIC REQUIRED MEDICAID SERVICES: Every Medicaid Program must cover at least these services for at least everyone receiving federally supported financial assistance: inpatient hospital care; outpatient hospital services; other laboratory and X-ray services; skilled nursing facility services and home health services for individuals 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; and physician services. Federal financial participation is also available to States electing to expand their Medicaid programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For a latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

♦ offered for people receiving federally supported financial assistance

★ offered also for people in public assistance 4/ and SSI 5/ categories who are financially eligible for medical but not for financial assistance

BASIC* REQUIRED MEDICAID SERVICES		Additional services for which Federal financial participation is available to States under Medicaid.																
SEE ABOVE		Clinic services	Prescribed drugs	Dental services	Prosthetic devices	Eyeglasses	Private duty nursing	Physical therapy and related services	Other diagnostic, screening, preventive and rehabilitative services	Emergency hospital services	Skilled nursing facility services for patients under 21	Optometrists' services	Podiatrists' services	Chiropractors' services	Care for patients 65 or older in institutions for mental diseases	Care for patients 65 or older in institutions for tuberculosis	Care for patients under 21 in psychiatric hospitals	Institutional services in intermediate care facilities
♦	ALABAMA		♦		♦	♦				♦	♦	♦				♦		♦ 6/
♦	ALASKA					♦				♦	♦	♦			♦		♦	♦ 6/
	ARIZONA																	
★	ARKANSAS	★	★	★	★					★	♦			★	★	★	★	♦ 6/
★	CALIFORNIA	★	★	★	★	★		★	★	★	★	★	★	★	★	★	★	★ 6/
♦	COLORADO		♦		♦			♦		♦	♦		♦		♦		♦	♦ 6/
★	CONNECTICUT	★	★	★	★	★	★	★	★		★	★	★	★	★		★	★ 6/
♦	DELAWARE	♦	♦					♦					♦		♦	♦		♦
★	D.C.	★	★		★	★		★	★	★	★	★	★		★	★	★	★ 6/
♦	FLORIDA		♦							♦					♦	♦		♦ 6/
♦	GEORGIA	♦	♦		♦				♦		♦		♦		♦	♦		♦ 6/
★	GUAM	★	★	★	★	★		★		★	★	★						
★	HAWAII	★	★	★	★	★		★	★	★	★	★						★
♦	IDAHO	♦	♦							♦	♦	♦	♦	♦				♦ 6/
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♦	IOWA		♦	♦	♦	♦		♦		♦	♦	♦	♦	♦				♦ 6/
★	KANSAS	★	★	★	★	★	★	★		★	★	★	★	★	★	★	★	★ 6/
★	KENTUCKY	★	★	★	★			★		★	★				★	★	★	★ 6/
♦	LOUISIANA	♦	♦		♦				♦	♦	♦			♦	♦	♦	♦	♦ 6/
★	MAINE	♦	★		★			★	★	♦	★		★	★	★		★	♦ 6/
★	MARYLAND	★	★		★	★				★		★			★	★		★ 6/

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★	MICHIGAN	★	★		★				★	★	★		★	★	★	★	★	★ 4/
★	MINNESOTA	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★ 4/
♦	MISSISSIPPI		♦	♦							♦				♦	♦		♦ 4/
♦	MISSOURI		♦	♦						♦		♦			♦	♦		♦ 4/
★	MONTANA	★	★	★	★	★	★	★	★	★	★	★	★		★		★	★ 4/
★	NEBRASKA	★	★	★	★	★	★	★		★	★	★	★	★	★	★		★ 4/
♦	NEVADA	♦	♦	♦	♦	♦	♦	♦		♦	♦	♦	♦	♦	♦			♦ 4/
★	NEW HAMPSHIRE	★	★		★	★	★	★	★	★	★	★	★	★	★			♦ 4/
♦	NEW JERSEY	♦	♦	♦	♦	♦		♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
♦	NEW MEXICO	♦	♦	♦	♦	♦	♦	♦		♦	♦	♦	♦					♦ 4/
★	NEW YORK	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★ 4/
★	NORTH CAROLINA	★	★	★		★			★		★	★	★	★	★	★	★	★ 4/
★	NORTH DAKOTA	★	★	★	★	★	★	★	★	★	★	★	★	★			★	★
♦	OHIO	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦		♦	♦ 4/
★	OKLAHOMA		♦	★									★		★		★	★ 4/
♦	OREGON	♦	♦	♦	♦	♦	♦			♦	♦	♦	♦	♦	♦	♦	♦	♦ 4/
★	PENNSYLVANIA	★	♦	♦	♦	★				★	★	★	♦	★	★		★	★ 4/
★	PUERTO RICO	★	★	★				★	★	★						★		
★	RHODE ISLAND		★	★	★	★						★	★		★			♦ 4/
♦	SOUTH CAROLINA	♦	♦	♦	♦	♦		♦		♦	♦	♦		♦	♦	♦	♦	♦ 4/
♦	SOUTH DAKOTA	♦	♦		♦	♦		♦		♦	♦	♦	♦	♦				♦ 4/
★	TENNESSEE	★	★		★					★					★	★	★	★ 4/
♦	TEXAS		♦	♦		♦				♦		♦	♦			♦		♦ 4/
★	UTAH	★	★	★	★	★	★	★		★	★	★	★	★	★		★	★ 4/
★	VERMONT	★	★		★					★	★		★		★		★	★ 4/
★	VIRGIN ISLANDS	★	★	★	★	★												
★	VIRGINIA	★	★			★		★		★	★	★	★		★	★		★ 4/
★	WASHINGTON	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★ 4/
★	WEST VIRGINIA	★	★	★	★	★	★	★			★	★	★	★	★	★		★
★	WISCONSIN	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★ 4/
♦	WYOMING										♦	♦						♦
21 32	♦ ★	13 29	21 30	12 22	14 27	12 24	5 14	10 22	5 17	18 25	18 25	15 23	14 23	10 18	14 27	11 19	8 21	25 25
53	Total	42	51	34	41	36	19	32	22	43	43	38	37	28	41	30	29	50

1/ Data from Regional Office reports of characteristics of State programs and State plan amendments.

2/ People qualifying as members of families with dependent children (usually families with at least one parent absent or incapacitated).

3/ People qualifying as aged, blind, or disabled under the Supplemental Security Income program.

4/ Including Intermediate Care Facilities in institutions for the mentally retarded.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. Social and Rehabilitation Service Medical Services Administration

Division of Program Monitoring

(SRS) 76-24801*

Who Pays For Medicaid?

Medicaid is financed jointly by federal, state and in some cases county funds. The federal government reimburses each state for a percentage of its Medicaid expenditures for medical services at a rate varying from 50 percent to 78 percent, depending on the state's per capita income. (For a list of the federal share of Medicaid expenditures by state, see Table 3.) Certain other costs are reimbursed at fixed rates of 75, 90 or 100 percent.

As we said above, Medicaid is a vendor payment program: the state agency that administers it pays health care providers directly for services given to an eligible individual. Federal regulations set ceilings on what states may pay providers participating in Medicaid for various services; federal law requires states to establish reimbursement rates high enough to assure sufficient providers in the program so that eligible persons can receive services to the same extent that they are available to the general public.[7]

Who Administers Medicaid?

At the federal level, until recently Medicaid was administered by the Medical Services Administration, a part of the Social and Rehabilitation Services (SRS) of the Department of Health, Education and Welfare. As a result of the recent plan reorganizing HEW, the Social and Rehabilitation Service agency was abolished and its component parts placed in other agencies. Medicaid (and EPSDT) are

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[7] 45 C.F.R. §250.30(a)(6). In addition, regulations also set ceilings on what a state may pay for a service. In the case of inpatient hospital care, the ceiling is "reasonable cost"--based on the hospital's actual costs for rendering a service to the extent that they are reasonable and related to patient care. (45 C.F.R. §250.30 (b)(1).) In the case of physicians and other providers of outpatient care, the ceiling is "reasonable charges"--generally, the lowest of the following: actual billed charges for the service; customary charge (the amount normally charged a majority of patients over the last calendar year); or the area's prevailing charge (charge which falls within the range of charges most frequently used in a locality for a particular medical service or procedure). (45 C.F.R. §250.30 (b)(3)(i).) With the exception of copayment requirements established by the state plan, Medicaid forbids a physician from charging sums to patients to make up the differences between the rate set by the state Medicaid agency and the actual cost for the service. (45 C.F.R. §250.30(a)(7).)

For more information on cost-sharing see: Butler, "The Medicaid Program: Current Statutory Requirements and Judicial Interpretations," p. 15; U.S. House of Representatives, "Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966-76," p. 3; and Lon Mullen and Andy Schneider, "Medicaid Cutbacks: A Handbook for Beneficiary Advocates" (Los Angeles, Calif.: National Health Law Program, 1976), p. 15.

Table 3

FEDERAL SHARE OF MEDICAID EXPENDITURES, BY STATE

State	Federal Share As A Percent Of Total	State	Federal Share As A Percent Of Total
Alabama	74	Montana	63
Alaska	50	Nebraska	56
Arizona	60	Nevada	50
Arkansas	75	New Hampshire	60
California	50	New Jersey	50
Colorado	55	New Mexico	73
Connecticut	50	New York	50
Delaware	50	North Carolina	68
District of Columbia	50	Ohio	54
Florida	57	Oklahoma	67
Georgia	66	Oregon	59
Guam	50	Pennsylvania	55
Hawaii	50	Puerto Rico	50
Idaho	68	Rhode Island	57
Illinois	50	South Carolina	74
Indiana	57	South Dakota	67
Iowa	57	Tennessee	70
Kansas	54	Texas	64
Kentucky	71	Utah	70
Louisiana	72	Vermont	70
Maine	71	Virgin Islands	50
Maryland	50	Virginia	58
Massachusetts	50	Washington	54
Michigan	50	West Virginia	72
Minnesota	57	Wisconsin	60
Mississippi	78	Wyoming	61
Missouri	59		

Source: Division of Program Monitoring, Medical Services Administration, Social and Rehabilitation Service, HEW. "Medicaid Services, State by State," June 1, 1976 (SRS)-76-24801).

in a new Health Care Financing Administration. The chief of this new agency is directly responsible to the Secretary of HEW. (For a picture of how the reorganization looks, see Table 4.)

Currently, each of HEW's ten regional offices has a regional Medical Services Administration office.[8] Each state designates one state agency--either the department of health, welfare or human resources, which may include both health and welfare--to design and administer the state's Medicaid program. This single state agency determines what optional services the program will include, what optional groups will be covered, if any, and how the program will be carried out in each locality across the state. (For a list of single state agencies responsible for Medicaid and EPSDT, see Appendix L in this report.)

The state Medicaid agency has the primary responsibility for assuring that both federal and state requirements are carried out. In addition, it must establish and maintain standards for quality services by, for example, licensing and certifying providers of care.[9] It also must review the quality of care given. (For a description and analysis of the federal administrative and enforcement responsibilities in this area, see Chapter 2 of this report.)

EPSDT

What Is It?

The Medicaid law was amended in 1967 to include preventive and curative health care services for children under age 21. Called Early and Periodic, Screening, Diagnosis and Treatment (EPSDT), this amendment to Title XIX of the Social Security Act *requires* every state operating a Medicaid program to provide EPSDT services to all children eligible for Medicaid.[10] Unlike Medicaid, EPSDT requires states not only to reimburse for services but also *to insure the provision of* periodic screening, diagnosis and treatment to eligible children. This means that states must do more than pay the doctors' bills. They must also see that EPSDT services are actually available to children whose families want them.

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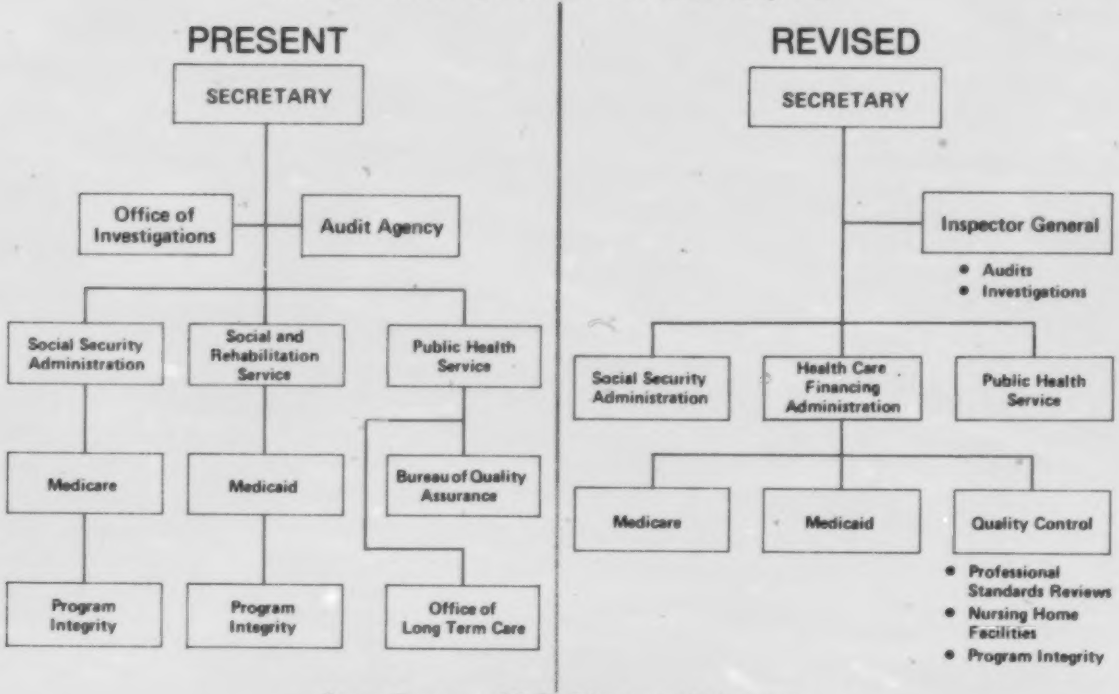
[8] We presume that federal reorganization will have its counterparts at the regional level as well as the federal level, but this has not yet been clarified.

[9] 42 U.S.C. §1396a(a)(9).

[10] 42 U.S.C. §1396d(a)(4)(B).

Table 4

ORGANIZATION FOR HEALTH CARE FINANCING


PRESENT
SECRETARY
Office of Investigations
Audit Agency
Social Security Administration
Social and Rehabilitation Service
Public Health Service
Medicare
Medicaid
Bureau of Quality Assurance
Program Integrity
Program Integrity
Office of Long Term Care
REVISED
SECRETARY
Inspector General
• Audits
• Investigations
Social Security Administration
Health Care Financing Administration
Public Health Service
Medicare
Medicaid
Quality Control
• Professional Standards Reviews
• Nursing Home Facilities
• Program Integrity

Source: Department of Health, Education and Welfare, 1977.

What Is Screening, Diagnosis and Treatment?

Screening is the use of quick, simple, relatively inexpensive procedures to identify and separate out apparently well persons from those who probably have a disease or problem requiring further attention.

Diagnosis is the determination of the nature and cause of a disease or abnormality. Diagnosis has two major purposes: (1) to confirm or disprove the positive results of a screening test; and (2) to develop a plan for dealing with a disease or abnormality if one indeed is found.

Treatment is all of the services needed to control and hopefully to cure a health problem. Broadly construed, treatment includes the prevention (e.g., through immunization), correction (e.g., through eyeglasses), or limitation of the effect (e.g., through counseling) of a disease or abnormality detected through screening and diagnosis.

Who Is EPSDT For?

All children under 21 years of age who are eligible for Medicaid are also eligible for EPSDT services. (See, again, Table 1.) As with other Medicaid services, receipt of EPSDT services is voluntary.

What Services Does EPSDT Provide?

EPSDT requires states to:[11]

(1) Pay for and make available screening services within 60 days of the time a family requests screening. To date, HEW has not mandated the specific procedures to be included in a screen but recommends the following be included at a time and frequency appropriate to the age of the child:

- Health and developmental history;
- Height, weight and other measures of physical growth;
- Developmental assessment;
- Unclothed physical inspection;
- Ear, nose, mouth and throat inspection, including assessment of dental condition;
- Vision testing;
- Hearing testing;
- Anemia test;
- Sickle cell test;
- Tuberculin test;
- Urine screening;
- Lead poisoning screening;
- Assessment of nutritional status;
- Assessment of immunization status; and

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[11] These requirements are spelled out in Medicaid regulations. (45 C.F.R. §249.10 (a)(3) and 45 C.F.R. §205.146(c).) Details on how they are implemented are found in Chapters 3-7 of this report.

- Other tests as appropriate (e.g., blood pressure, chest X-ray, pinworm slide).[12]

(2) Make available and pay for diagnostic services for eligible individuals found through the screening process to be in need of further diagnosis.

(3) Make available and pay for treatment as needed by the child within the amount, duration and scope of the state Medicaid plan. In addition, make available and pay for eyeglasses, hearing aids, other kinds of treatment for visual and hearing defects and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health, regardless of whether such treatment is included in a state's plan. Such diagnosis and treatment must be provided normally within 60 days of screening.

(4) Develop an outreach program to inform eligible families that services are available and where and how they can be obtained.

(5) Seek out and develop agreements with existing facilities and practitioners in the state that can provide EPSDT services.

(6) Make available needed transportation to and from services.

Beyond the screening, diagnosis and treatment services that a child receives through EPSDT, like any Medicaid recipient, a child is entitled to all other services covered by a state's Medicaid program. This means, for instance, if a child eligible for Medicaid has a sore throat or an earache and needs to see a physician, he or she may go to any certified provider that accepts Medicaid patients.

Who Pays For What?

EPSDT is financed through Medicaid, and as with Medicaid, states are reimbursed for screening, diagnosis and treatment costs by the federal government at a rate ranging from 50 percent to 78 percent, again depending on the state's per capita income. Most administrative costs are reimbursed at 50 percent; some outreach and follow-up costs at 75 percent. The cost of operating data systems is reimbursed at 75 percent, but the cost of developing such a system is reimbursed at 90 percent.

As in Medicaid, reimbursement for services is paid by the state agency directly to the individual or organization providing those services, and rates are set by the states within the broad Medicaid requirements described previously. The rates for screening children under EPSDT vary. (See Table 5 for fee schedules for EPSDT screening in each state.)

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[12] *Medical Assistance Manual*, Part 5, 5-70-20(E)(7).

Table 5
FEE SCHEDULES FOR EPSDT SCREENING PACKAGES BY STATE

	Fee Schedule		
	Pkg. Rate[1]	By Ind. Proced.[2]	Pkg.+ Lab.[3]
Alabama	$23.50		
Alaska	not available		
Arizona			
Arkansas	$19-$24		
California	$22-$27		X
Colorado	$24.00		
Connecticut	$15.75		
Delaware	$17.50		
District of Columbia	$28.00		
Florida	$6.25		
Georgia	$16.00		
Guam			
Hawaii	$18-$30		
Idaho	$50-$75[4]		
Illinois	$16.00		
Indiana	not available		
Iowa		X	
Kansas	$25-$30		
Kentucky	$12.00		
Louisiana	$42.19 (average)		
Maine	undetermined		
Maryland	$30.00	X	
Massachusetts	$22-25		
Michigan	$22-$29		
Minnesota	$17.60		
Mississippi	$17.00		
Missouri	$15.00	X	
Montana	$13.00		
Nebraska	$16-$20	X	
Nevada	$10-$30		
New Hampshire	$23.50		X
New Jersey	$14-$21		
New Mexico	$18.40		
New York	$21-$35		
North Carolina	$15.00		
North Dakota			
Ohio	$40.00 (maximum)		
Oklahoma	$9.00		
Oregon	$13.00	X	
Pennsylvania	$12-$24		
Puerto Rico	undetermined		
Rhode Island	$20.00		
South Carolina		X	
South Dakota	$15.00		
Tennessee	$10.00		
Texas	$21.50		
Utah	$16.00		
Vermont	$20.00		
Virgin Islands	$20.00		
Virginia	$12.00		
Washington	$6-$13.51		
West Virginia	$18-$20		
Wisconsin	$19.21		
Wyoming	$15.00		

[1] Rate per total screening package

[2] Rate by individual components or procedures

[3] Rate per screening package plus laboratory tests

[4] Including other costs, e.g., administration, outreach

Source: Medical Services Administration, Social and Rehabilitation Service, HEW, Working Data, 1977.

Who Administers EPSDT?

At the federal level, EPSDT is administered by the Health Care Financing Administration as part of Medicaid. While there is a Division of EPSDT in Washington, D.C., HEW regional offices have no sub-divisions specifically for the EPSDT program, although there are individuals working on EPSDT.

In all states, EPSDT is administered by the single state agency designated to handle Medicaid. The single state agency has ultimate responsibility to assure that all program requirements are carried out, but it may assign responsibility for various functions--finding and informing families, screening, diagnosing, treating, case managing, providing transportation --to different departments of state government. (See Table 6 for a list of which state agency has responsibility for outreach, follow-up and transportation under EPSDT.)

Who Provides EPSDT Services?

Federal requirements leave states freedom to determine how EPSDT services will be made available. Agencies in the states may subcontract with organizations and individuals at the local level to provide services. For instance, the state welfare department may have local welfare agencies perform outreach and provide transportation. It may also contract with the state health department, which in turn may use county health departments, to do screening.

In 25 states and territories, screening is provided primarily in public health department clinics; in 8 states, primarily by private physicians; and in 20 states, by a range of providers, including health departments, physicians, outpatient departments of hospitals, comprehensive community health centers and clinics, and schools and day care centers.[13] (See Table 7 for a list of screening providers in each state.)

Like screening, diagnostic and treatment services are provided by a wide variety of sources. In almost every state, private physicians as well as other providers furnish treatment services. Responsibility for follow-up services (making sure a child gets needed services following screening) is assumed by state welfare departments in 23 states, by health departments in 9 and in 12 states by both health and welfare.

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[13] Preliminary results of a 1977 survey show that distribution of types of screening providers has changed somewhat: 19 states and territories use primarily health department clinics, 5 use private physicians and 28 use a combination of providers. (Medical Services Administration, "Working Data," Washington, D.C.: HEW, 1977.)

Table 6

STATE AGENCIES ASSUMING RESPONSIBILITY FOR OUTREACH, FOLLOW-UP AND TRANSPORTATION

	OUTREACH				FOLLOW-UP TO TREATMENT				FOLLOW-UP TO TREATMENT				TRANSPORTATION			
	DPW[1] DSS[2]	DPH[3]	UMBR AGCY[4]	OTHER	DPW DSS	DPH	UMBR AGCY	OTHER	DPW DSS	DPH	UMBR AGCY	OTHER	DPW DSS	DPH	UMBR AGCY	OTHER
ALABAMA		▨			▨	▨			▨	▨			P[6],A[6]	P,A		
ALASKA	▨	▨				▨				▨			7			
ARIZONA																
ARKANSAS	▨	▨			▨	▨				▨			P,A			
CALIFORNIA		▨			5				5					A		
COLORADO		▨			▨				▨				A			
CONNECTICUT	▨				▨			▨	▨							
DELAWARE	▨					▨				▨						
D.C.			▨			▨				▨						
FLORIDA			▨		▨				▨				P,A			
GEORGIA			▨		▨				▨				P,A			
GUAM																
HAWAII	▨					▨				▨			A			
IDAHO	▨					▨				▨						
ILLINOIS	▨				▨				▨							
INDIANA	▨				▨					▨						
IOWA	▨				▨				▨	▨			A			
KANSAS	▨				▨	▨			▨	▨			A			
KENTUCKY			▨		▨				▨				P,A			
LOUISIANA	▨	▨			▨	▨				▨			P,A	P,A		P,A
MAINE	▨							▨				▨				
MARYLAND	▨		▨			▨		▨		▨						

MASSACHUSETTS	▨							▨				▨				
MICHIGAN	▨									▨						
MINNESOTA	▨				▨				▨							
MISSISSIPPI				▨	▨	▨				▨	▨		P,A			
MISSOURI			▨		▨				▨						A	
MONTANA	▨		▨		▨				▨			▨	A			
NEBRASKA	▨				▨				▨				A			
NEVADA	▨				▨	▨			▨	▨			A			
NEW HAMPSHIRE	▨							▨								
NEW JERSEY	▨			▨			▨	▨			▨	▨			P,A	P,A
NEW MEXICO	▨				▨				▨				P,A			
NEW YORK	▨				▨	▨			▨				P,A			
NORTH CAROLINA			▨		▨				▨				P,A			
NORTH DAKOTA	▨				▨								A			
OHIO	▨				▨				▨							
OKLAHOMA	▨				▨				▨				P,A			
OREGON	▨			▨	▨	▨		▨	▨							
PENNSYLVANIA	▨				▨			▨	▨							
PUERTO RICO	▨			▨	▨	▨			▨	▨			P,A			
RHODE ISLAND	▨				▨				▨							
SOUTH CAROLINA	▨				▨				▨				P,A			
SOUTH DAKOTA	▨				▨				▨			▨	A			A
TENNESSEE		▨			▨				▨				P,A			
TEXAS	▨				▨				▨				P,A			
UTAH	▨				▨	▨										
VERMONT	▨					▨				▨						
VIRGIN ISLANDS		▨			▨	▨			▨	▨			P,A			
VIRGINIA		▨				▨			▨	▨						
WASHINGTON	▨					▨		▨		▨						
WEST VIRGINIA		▨		▨	▨	▨		▨	▨	▨		▨				
WISCONSIN	▨				▨					▨						
WYOMING	▨		▨		▨				▨			▨			A	

1 Department of Public Welfare
2 Department of Social Services
3 Department of Public Health
4 Umbrella Agency
5 Provides transportation directly
6 Arranges for transportation
7 Where blank, data unavailable to HEW
8 Varies by county

Source: Medical Services Administration, Social and Rehabilitation Service, HEW, "Working Data," 1977.

Table 7

SCREENING PROVIDERS USED BY STATES
FOR THE EPSDT PROGRAM

Health Departments (Only)	Private Physicians (Only)	Mixed Group of Providers
Alabama	Indiana	Alaska
Arkansas	Nebraska	California
Delaware	Nevada	Connecticut
District of Columbia	New Hampshire	Idaho
Florida	Ohio	Illinois
Georgia	Oklahoma	Iowa
Guam	South Dakota	Maine
Hawaii	Wyoming	Massachusetts
Kansas		Minnesota
Kentucky		Missouri
Louisiana		New Jersey
Maryland		New York
Michigan		North Dakota
Mississippi		Oregon
Montana		Pennsylvania
New Mexico		Rhode Island
North Carolina		Utah
Puerto Rico		Vermont
South Carolina		Washington
Tennessee		
Texas		
Virgin Islands		
Virginia		
West Virginia		
Wisconsin		

Source: Medical Services Administration, Social and Rehabilitation Service, U. S. Department of Health, Education and Welfare, "Working Data, 1975."

Transportation services are either provided directly or arranged for by the responsible agency. In many states, the Department of Public Welfare, is responsible for providing or arranging for such services.

What Do EPSDT and Medicaid for Children Cost?

It is impossible to say with precision how much EPSDT costs since the costs of many of its components are not reported independently from the rest of Medicaid. Generally, screening costs are separated from other Medicaid expenditures, but diagnostic and treatment costs are not. To gain some perspective on the costs involved, in fiscal 1976, Medicaid for *all* eligible recipients cost a total of approximately $15 billion, with about $2.6 billion paying for services delivered to eligible children.[14]

Health services for children are relatively low in cost. The annual cost per child for *all* Medicaid services was $230. Thus, while children made up 47 percent of Medicaid recipients, payments to providers for health care services for children made up only 19 percent of Medicaid expenditures.[15] Rough estimates indicate that EPSDT services currently cost about $136 million annually, with a federal share of $75 million and a cost per child of $68.[16] In addition, in fiscal 1976, states with active EPSDT programs spent less than 1 percent of their Medicaid funds on EPSDT screening and administration.[17]

Evidence of whether EPSDT is cost-effective is just beginning to come in. In a recent study of EPSDT costs in one state, when children who had been screened were matched against their Medicaid-eligible but unscreened counterparts, they needed significantly less hospital care; they were in the hospital 55 percent fewer days; and they had 26 percent fewer physician visits outside of offices (e.g., in hospitals) than those who had not been screened.[18]

How Does EPSDT Usually Work?

Given the wide latitute states have for implementing EPSDT, and given the variation in local needs and circumstances, there is no one way that typifies how EPSDT services are delivered to children.

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[14] Task Force on Human Resources, Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," *Working Papers on Major Budget and Program Issues in Selected Health Programs* (Washington, D.C.: Committe on the Budget, U. S. House of Representatives, 10 December 1976), p. 29; and Medical Services Administration, Budget Office, "Working Estimates" (Washington, D.C.: HEW, 1977).

[15] Medical Services Administration, Budget Office, "Working Estimates."

[16] Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," p. 129.

(See Table 8 in this chapter for a breakdown of estimated costs under EPSDT.)

[17] Medical Services Administration, "EPSDT: The Possible Dream," (Washington, D.C.: HEW, 1977), p. 11.

[18] Applied Management Sciences, "Assessment of EPSDT Practices and Costs--Report on the Cost Impact of the EPSDT Program" (Silver Spring, Md.: Applied Management Sciences, December 10, 1976), pp. 23, 28.

Table 8

ESTIMATED COSTS OF EPSDT

Component	Cost of Component	Total Program Costs[1]
Outreach	$1.00 per eligible child	$13,000,000
Screening	$21.00 per child screened	42,000,000
Followup	$10.40 per child with referral	13,000,000
Treatment (including diagnosis and immunizations)		
- Medical	$35.00 per child treated	21,000,000
- Dental	$90.00 per child treated	27,000,000
Administration	$10.00 per child in EPSDT system	20,000,000
TOTAL		$136,000,000
Estimated Federal Share (at 55 percent)		$74,800,000
Average Cost per Child in EPSDT		$68.00

[1] Costs projected on the basis of services provided in fiscal year 1976

Source: Congressional Budget Office, "Working Papers on Major Budget and Program Issues in Selected Health Programs," 1976, p. 129.

But there are patterns that we found in many places. The story below is a composite of how EPSDT is often administered. It gives a picture of how the laws and regulations described above in this chapter are translated into human terms.

For an eligible child, EPSDT usually begins at the welfare office. When a family like the Dougals go there for certification for AFDC, SSI or Medicaid, a caseworker hands them a brochure or a letter explaining that a program called EPSDT exists and that Mrs. Dougal can take her daughter, Sally, for health services if she wants to. Mrs. Dougal is not sure what screening and EPSDT are, and the caseworker explains what kinds of services EPSDT provides, why they are important to Sally's well-being and where and how services can be obtained. Mrs. Dougal agrees that Sally should be screened, and the caseworker refers them to the health department for EPSDT screening and helps them make an appointment. She also asks if the Dougals need help getting to the health department, but Mrs. Dougal says that a neighbor will drive her and Sally there and back.

At the health department, a nurse helps Mrs. Dougal fill out a health history for Sally, who receives a complete unclothed physical exam, vision and hearing tests, a nutritional assessment, a dental assessment and urine and blood tests for a variety of conditions or diseases. Sally checks out fine on all but the blood test, and the nurse asks Mrs. Dougal if she has a regular doctor to go to for follow-up care for Sally. Mrs. Dougal replies that she doesn't, so the health department nurse arranges an appointment with a pediatrician nearby for further diagnosis and possible treatment.

Unfortunately, on the day of the appointment, Mrs. Dougal's neighbor cannot drive them. Mrs. Dougal calls the welfare department, and a social worker there tells her to take a bus to the doctor and to submit a claim for reimbursement.

Sally is found to need iron supplements and EPSDT pays for the medication. The first round of EPSDT is now completed. In two years when Sally's turn to be rescreened comes up, if she is still eligible for Medicaid and EPSDT, the process will begin again.

Chapter 1

What Have We Learned and Where Do We Go From Here?

Archie Douglas is now eight years old and has already failed the first grade twice. He has always avoided going to school whenever possible. Last year his teacher reported that when in class, he had a short attention span, misbehaved frequently and was generally disruptive. After two years of first grade instruction, his language skills are those of a five year old. This is true despite the fact that he excels in the nonverbal portions of standardized intelligence tests. Archie comes from a stable, intact, lower-income family.

Archie was a full-term, normal healthy baby. He received his health care during infancy from a city clinic. When he was 18 months old, he had a fever and an earache. His mother, relying on her mother's advice, rocked him to soothe his crying and ease Archie's pain, gave him half an aspirin every few hours and used a commercial ear-drop preparation. While rocking him, his mother noticed that some fluid began draining from his ear. Archie seemed less distressed after the fluid drained, and he recovered completely within a few days.

Three months later the fever and the earache recurred. This time both ears were affected. Home remedies brought no relief and Archie was taken to the clinic. The doctor diagnosed bilateral otitis media. This is a common childhood illness, easily diagnosed, and easily and effectively treated by antibiotics. Mrs. Douglas was able to pay $15 for antibiotics only by deferring her rent payment. Because Archie seemed to recover in a few days, his mother discontinued the medication prescribed by the doctor before the full antibiotic regimen was completed. Within a month, the condition returned, and this time rocking, ear drops and a few left over antibiotic pills were administered and Archie seemed to recover.

With the exception of these illnesses, Archie was a healthy, active child. Other than visits to the clinic for immunizations, his mother was grateful that he never needed to see a doctor.

This year Archie has a new first grade teacher. On his recommendation, Archie's mother took him to a speech and hearing center for an evaluation. They found that Archie has a bilateral hearing loss that probably resulted from his early bouts with otitis media. He has slightly more hearing in his left ear (30 dB) than in his right (45 dB). Archie's hearing loss is considered significant. He has frequent difficulty with normal speech sounds, and his difficulty has probably been the cause of his school problems. Archie's hearing problem can be alleviated by a hearing aid, but at this point, he also needs remedial education and his mother needs counseling and support. Even with help, it will be difficult for Archie to overcome his initial impressions that school is incomprehensible, that he cannot keep up and that he is a failure.

Archie could have been spared much of his suffering through a program of early screening and follow-up care. While it is unlikely that screening could have identified his ear infection when it first developed (unless his screening appointment happened to be scheduled when he was sick), screening within the next year or so would have identified the hearing loss much earlier, when he was two or so years old, long before it seriously affected his language skills. Once his problem was identified, Archie could have gotten a hearing aid and services in school suited to his special needs.

EPSDT's Origins and Promise

Late in 1967, Congress amended Medicaid to require states to provide "early and periodic screening, diagnosis and treatment" (EPSDT) to all children under the age of 21 who were eligible for the Medicaid program.[1] Although the language of the EPSDT amendment was extremely general and the legislative history sparse, the outlines of the program Congress intended were quite clear. Children eligible for Medicaid--estimated then to be approximately 6.5 million and now about 13 million--were to receive complete physical examinations and other screening procedures such as tests for vision and hearing deficiencies, for high levels of lead in the blood, for nutritional deficiencies, for dental problems and for other problems that could impede their normal growth and development. These screening procedures were to start early, preferably soon after birth, and were to be repeated periodically until the child reached age 21. Following screening, children were to receive the diagnostic and treatment services indicated necessary during their health assessments. It was hoped that this system of early detection and follow-up would control most chronic disorders suffered by poor children before they did permanent and costly damage.

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[1] 42 U.S.C. §1396d(a)(4)(B). Congress enacted at the same time an amendment to the federal Maternal and Child Health Program (Title V of the Social Security Act), calling for early identification of children in need of health care and treatment to correct their health problems. (42 U.S.C. §705(a)(7).) These were part of the Child Health Act of 1967.

The backdrop for EPSDT's enactment included three critical developments during the 1960s. First, a growing public concern for the poor led to the creation of Great Society anti-poverty programs, which tried to break the cycle of poverty by improving the lives of poor children. Second, a number of categorical health programs as well as Medicaid and Medicare became law, creating a precedent for federally-subsidized health services.

Finally, the striking prevalence of chronic, handicapping conditions in children was being brought to the attention of the public. A Selective Service study found that more than 15 percent of 18 year olds examined for military duty were rejected because of conditions including dental, eye and ear problems; orthopedic problems; internal conditions such as heart disease; and a large percentage of emotional and developmental disorders.[2] Based on a review of medical literature, a group established by HEW estimated that 62 percent of the serious conditions found by the Selective Service were preventable or correctable through comprehensive and continuous health care. Thirty-three percent were estimated to be preventable or correctable through periodic screening and treatment.[3] The group also found that disabling conditions and inadequate care were far more common among poor children:

> Two-thirds had never been to a dentist; 60 percent of those with chronic conditions were not being treated. Physician visits were less frequent, although there was nearly twice as much hospitalization as among higher-income children.
>
> Compared to more affluent children, the prevalence of heart disease was three times as great. Seven times as many low-income children had visual impairments, six times as many had hearing problems, and five times as many had mental illness.[4]

It was to deal with these problems early--and cost effectively--that EPSDT was established.[5]

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[2] These preliminary data were based on rejection rates in Selective Service examinations of 18-year-old, non-college bound youth from July 1964 to December 1965 under the "Conservation of Manpower" program. See Bernard Karpinos, Office of the Surgeon General, Department of the Army, cited in "Maternal and Child Health Care Programs," (Washington, D.C.: Office of the Assistant Secretary for Program Coordination, HEW, October 1966), Table 2.7.

[3] "Maternal and Child Health Care Programs," p. II.8.

[4] Task Force on Human Resources, Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," *Working Papers on Major Budget and Program Issues in Selected Health Programs* (Washington, D.C.: Committee on the Budget, U.S. House of Representatives, 10 December 1976), p. 119.

[5] For more detailed analysis of the history and development of EPSDT during this period see, for example, Task Force on Human Resources, Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," pp. 117-136; Anne-Marie Foltz, "The Development of Ambiguous Federal Policy: Early and Periodic Screening,

EPSDT held a great deal of promise. First, it could begin to fill in the major gaps in the health care poor children received. And the need was great. Poor children suffered disproportionately from nutritional deficiencies, hearing and vision impairments, dental problems, parasites and skin diseases such as impetigo.[6] They suffered not only from poverty, substandard housing and nutritional deficiencies that caused or aggravated their health problems, but from the lack of health care to attend to them. The national immunization rates for polio and for other childhood diseases--good indices of whether children were receiving the most basic preventive care--were especially low for children living in poverty areas. In 1975, 47 percent of children under one year of age living in large metropolitan areas designated as poor had not received *any* polio vaccine; 58 percent of poor infants below age one in large central cities had not received shots for diphtheria, tetanus or whooping cough.[7] One study noted that poor children were more in need of medical care when they finally saw a doctor, even though they saw physicians less often than more affluent children.[8] Another showed that poor families in a central city area received medical services only 15 percent of the time their symptoms indicated they needed care.[9] Not surprisingly, poor children suffered the consequences of inadequate health care. They had twice as many hospital stays, spent more sick days in bed and lost more days of school than non-poor children.[10]

Diagnosis and Treatment (EPSDT)," *Milbank Memorial Fund Quarterly* (Winter 1975); and Joseph A. Wholey, *The Absence of Program Evaluation As An Obstacle to Effective Program Expenditure Policy: A Case Study of Child Health Care Programs* (Washington, D.C.: Urban Institute, 1970).

[6] For summaries of evidence on the health problems of poor children see, for example, Office of Child Health Affairs, "A Proposal for New Federal Leadership in Maternal and Child Health Care in the United States," (Washington, D.C.: HEW, November 1976), pp. 9-10, 15 (draft); and *Doctors and Dollars Are Not Enough* (Washington, D.C.: The Children's Defense Fund, 1976), pp. 10-11.

[7] Center for Disease Control, *United States Immunization Survey: 1975*, (Washington, D.C.: HEW, Publication No. (CDC) 76-8221, June 1976), Tables 4, 4c, 5, 5c, pp. 25, 28-29, 33, and 36-37.

[8] Data from the *Health Interview Survey*, cited in John A. Butler, "Improving the Delivery of Primary Medical Care Services for American Children" (Cambridge, Mass: Harvard Child Health Project, September 1975, unpublished and unpaged draft report).

[9] Alpert, et al., cited in Butler, "Improving the Delivery of Primary Medical Care Services for American Children."

[10] Medical Services Administration, "EPSDT: The Possible Dream" (Washington, D.C.: Social and Rehabilitation Service, HEW (SRS-FY 77-24-973), February 1977), p. 1. (Mimeo.)

Second, EPSDT represented the first major commitment in this country to reach large numbers of children in desperate need of basic health care. Prior to EPSDT, only a few federally-financed health programs provided health services to poor families and children, but these programs reached only a very small percentage of the poor children who needed them. Medicaid, which reached a great number of poor families, paid for treatment for acute medical problems or emergencies. Rarely were its resources used to prevent or treat children's health problems early in their course.

And finally, not only did EPSDT focus on preventive services for an extremely large number of children, but it placed an affirmative obligation on the state agencies administering Medicaid to take steps to ensure that eligible children actually received the services they needed. States were to inform eligible families about the availability of EPSDT and about the value of preventive health care so that families could take advantage of the program. In addition, states had the responsibility to see that there were enough providers in the program so that all eligible children who wanted to use EPSDT services were able to receive them promptly. These affirmative obligations drastically altered the passive role which states had assumed previously in the Medicaid program--a role which had resulted in children's minimal receipt of preventive health care and in the absence of services in many parts of the country where providers had chosen not to participate in the program.

In short, to carry out EPSDT, state Medicaid programs had to move beyond their limited role of paying bills for health care to the more important and difficult role of seeing to it that health services were actually provided.

CDF Study

We had been concerned for a number of years with health services for children in general and with the development and improvement of EPSDT in particular. In 1975, after pressing HEW for several years to implement the EPSDT program more fully, we decided to look at how well EPSDT was fulfilling its promises. We wanted to know to what extent it was providing poor children with the health care we believed they needed;[11] what improvements were necessary for EPSDT to serve them properly; and what lessons could be learned from EPSDT for designing a program of national health insurance that would meet the needs of children and families. Specifically, we wanted to know how EPSDT measured up against six criteria that are basic to providing quality health care to children, whether through EPSDT or through other programs:

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[11] The principles we believed necessary for effective health care for children are articulated in our first report on child health, *Doctors and Dollars Are Not Enough* (Washington, D.C.: Children's Defense Fund, 1976).

1. Was the program administered and enforced in such a way to assure children the benefits to which EPSDT entitled them?
2. To what extent was EPSDT reaching children who needed its services?
3. Were children's health problems being identified by screening?
4. Were the necessary diagnoses and treatments being provided?
5. How was the developmental assessment part of the program working and was it finding and helping children with developmental needs?
6. Was EPSDT linking children to sources of continuing health care?

To answer these questions, we studied five states' programs in various parts of the country and focused on one county in each state: Essex County (Newark), New Jersey; Florence County, South Carolina; Genesee County (Flint), Michigan; Oktibbeha County, Mississippi; and Suffolk County (eastern Long Island), New York. These programs presented a variety of administrative approaches and designs for implementing EPSDT,[12] and the areas represented a wide spectrum of ethnic, demographic, and geographic differences.[13] Also, all of these programs had been implemented relatively early in the history of EPSDT and, we hoped, were far enough advanced to have information on the questions we asked and to shed light on the problems other EPSDT programs would face after they moved beyond the initial start-up stage.

We collected whatever data existed from our study sites as well as for the program nationwide.[14] We reviewed laws, regulations, guidelines, and federal and state policies governing how EPSDT was supposed to work, and we looked closely at the local policies and practices in our study sites. We visited each county and talked with parents, program administrators, physicians, dentists, state and county Medicaid agency personnel,[15] staff at neighborhood health centers, hospital outpatient clinics, welfare agencies, schools, Head Start and other child care centers and various community organizations.[16]

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[12] See Appendix G for summary information on how EPSDT requirements were carried out in each of our study sites. Note that in New York State the EPSDT program is called CHAP, but for the sake of consistency in our report, we refer to it as New York's EPSDT program.

[13] For more discussion of how we chose our study sites and a description of them, see Appendix A.

[14] Information from our study sites was current as of the time of our visits, which were made between September 1975 and February 1976. Where more recent national data were available, we have collected it. It should be noted, however, that there were few reliable quantitative data about EPSDT, which was one of the most serious shortcomings of the program and which made it necessary to collect and use other kinds of information in assessing the program.

While the examples, stories and judgments come from five counties, we believe the lessons we have learned from them illustrate the progress and problems of EPSDT across the country.

Summary of CDF Findings

Have EPSDT's promises for health care for poor children been fulfilled? We found that they had been, but for very few children. We found that EPSDT had certain built-in limitations preventing it from being the best answer to children's health needs. Many of these deficiencies, however, can be corrected. We found too, that many of the changes needed to make EPSDT serve children better can be accomplished within existing law. As we have found, the health needs of children make it imperative that these improvements be made.

Our findings are summarized below. In Chapter 2 we look more closely at administration and enforcement questions, and in Chapters 3 through 7 we set forth detailed findings from our study as well as recommendations for each of the issues we looked at in the performance of EPSDT.

1. Many needy children were not reached by EPSDT screening.[17]

First, because it is tied to Medicaid eligibility criteria, EPSDT reached only a portion of children living in families too poor to pay for health care. Of the 23 million children living in families earning 150 percent of the poverty level (an income of about $7,500 for a family of four, covering only the necessities, with none left to pay for major medical expenses), only 13 million, or 56.4 percent of them, were eligible for Medicaid and EPSDT. The rest of the needy children remained out of EPSDT's reach.

But even among the 13 million children who were eligible, too few received EPSDT's services. While the screening rates increased steadily between fiscal 1973 (when 500,000 screenings were done) and 1976 (when 1.7 million screenings were done), these numbers still mean that only a fraction of eligible children who should have been screened were reached. Using the American Academy of Pediatrics' (AAP) screening schedule as a base for calculating expected screening rates, to date EPSDT has performed 5.4 percent of the screenings needed by eligible children. In 1976, it provided only 25.8 percent of assessments children needed that year. Actual performance varied greatly from state to state. In our study states, rates ranged from a low in New Jersey, which failed to carry out almost 19 out of every 20 screenings required to meet the AAP's standard, to a high in South Carolina, where 2 out of every 5 needed screenings were done.

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[15] New York was the only state in which we did not visit the state offices. We did, however, conduct several telephone interviews with state agency personnel.

[16] For a complete list of people interviewed in our study sites, see Appendix B.

[17] The bases for and further discussion of these findings are in Chapter 3.

According to our survey, there were a number of important reasons why so few poor children were actually being screened through EPSDT:

--Large numbers of eligible families were not adequately informed about EPSDT because the outreach methods adopted by the states were ineffective. States relied on written notices and conversations at welfare offices to inform families about the program, even though the evidence is clear that these forms of outreach alone are not successful. Methods proven to be effective, namely, personal outreach by people or organizations serving the community, seldom were used.

--Children who are in need of screening remain unreached because, in an effort to target outreach efforts on those most in need, states erroneously assumed some children were receiving "equivalent care," and therefore did not need EPSDT services. As one person put it, "They are spending more money trying to prove that particular children don't need care than to serve them."

--Even when outreach was effective, some children did not get EPSDT services because sufficient screening providers often were not available to serve all families. In many places, because of the state's reluctance to use all available providers, particularly neighborhood clinics and other trusted, community-based organizations, providers that were used were inconveniently located or unacceptable to families.

--Even though assuring needed transportation to and from EPSDT services is required by law, many families were unable to obtain the necessary transportation to bring their children to the screening site.

--Not only have many needy children never been screened for the first time, CDF's survey shows that almost no children were rescreened periodically, as Congress intended. Frequent changes in eligibility for

Medicaid have resulted in a turnover rate of approximately 30 percent of children each year. This means that about 34.7 percent of children eligible during the year drop out of the program before they can be screened or rescreened. For those who regain eligibility or stay in the program, few states have developed systems allowing staff to keep track of and rescreen children at the proper times.

2. While screening uncovered a host of unmet health needs, screens were often incomplete and inadequate.[18]

EPSDT screenings have found many unmet health problems in poor children. Nationally in fiscal year 1976, for every three screens, two conditions were found needing follow-up care. Between 60 and 80 percent of these problems were previously unidentified or uncared for.[19] Fewer than 1 percent of children screened in EPSDT had ever received a comparable physical examination.[20] Screenings uncovered such problems as incomplete immunizations, dental problems, low hemoglobins (indicating iron deficiency anemia), vision and hearing problems, high levels of lead in the blood, genitourinary and respiratory infections, parasites and skin diseases.

But although EPSDT was finding these problems, CDF found that screening in EPSDT programs was frequently not carried out thoroughly. We found great variations in the incidence of conditions found from program to program and state to state. These differences were too large to be explained solely by differences in the health of children in various places. For example, in Oktibbeha County, Mississippi, for every 2 screenings, 3 conditions were found, while in Florence County, South Carolina, for every 5 screenings, 1 condition was found. Rather, we found a variety of inadequacies in the way screening was performed:

--Health histories, which provide the information for identifying the majority of children's health problems, were inadequate or were sometimes not taken at all. Because parents were not encouraged or were unable to accompany their children during the hours screening was performed, they often could not give or supplement health history information.

--Certain essential procedures were omitted from the set of services states decided to offer. In practice, even procedures that were included in states' screening packages were omitted, particularly vision and hearing testing and dental referrals.

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[18] The bases for and further discussions of these findings are in Chapter 4.

[19] Harry W. Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974-March 1975* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, January 1976), p. iv.

[20] Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975*, p. v.

--The special needs of adolescents were not taken into account when designing or implementing states' screening services, most of whose procedures are relevant to young children.

--Qualified personnel (including health aides and physician extenders) were frequently not used to perform screening and, conversely, some of the persons who were screening children were not sufficiently trained or supervised.

3. Many children did not receive the diagnoses and treatment they were found to need.[21]

Despite a statutory requirement that indicated diagnosis and treatment must be available within 60 days after screening, only about 60 percent of referred conditions ever received follow-up care. Thus, of the approximately 1.1 million conditions referred for follow-up care in fiscal year 1976, about half a million conditions were not treated. CDF found a variety of reasons for this failure:

--The 30 percent turnover rate among eligible children meant that many children dropped out along the path between screening and diagnosis, diagnosis and the start of treatment, or start to finish of treatment.

--In spite of the clear Congressional intent for EPSDT to treat all problems found in screening, federal regulations allowed states to limit the services they covered in their Medicaid plan and, as a result, certain treatment services indicated by screening were not paid for. For example, in some places, speech therapy, orthopedic shoes, mental health counseling, eyeglasses for certain needy children, dermatological services and certain kinds of dental care were not covered.

--We found, too, that many problems uncovered in screening called for the combined skills of social workers, health educators, counselors or others whose services were not covered under Medicaid.

--EPSDT's separate screening and treatment components, often provided at separate locations and at different times, meant many children were lost in the treatment maze. Even basic services such as immunizations or topical medication for a rash often were not provided at the time or in the same place as screening.

--We found, too, that there were too few or the wrong kinds of providers for diagnosis and treatment, and states had not taken adequate steps to encourage providers to participate in EPSDT or to arrange for needed care. In some of our study sites, we found shortages of general pediatric care; in others, there were too few resources for dealing with children's special needs (cardiac, dental, dermatological, developmental). When we randomly called half of all the dentists in Florence County, only *one* took Medicaid patients without restrictions.

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[21] The bases for and further discussion of these findings are in Chapter 5.

--With few exceptions, states had not set up adequate case management systems capable of following children to assure that needed treatment was received.

4. The capacity of EPSDT to find and help children with developmental problems was limited.[22]

Congress originally mandated that screening be done for "mental" (later defined as "developmental") as well as "physical" defects. The need for such services clearly exists. Large numbers of children suffer from perceptual, motor and cognitive difficulties that impair their growth and development. But disagreement among professionals regarding the suitability of a medical screening program and the appropriateness of available instruments for finding children with such problems has hindered the development of this part of the EPSDT program. In addition, we found that the ways the program was operating further limited its effectiveness in finding and assisting children with developmental problems:

--Parental involvement was minimal. Scant information was given to parents about the developmental assessment component of the program. In most places we visited, parents were not asked about their child's development. And in the rush to get basic procedures done, informing and counseling families about screening results and the next steps to take to follow up suspected problems often were omitted.

--Twenty-seven states report using the Denver Developmental Screening Test (DDST) even though its norms were not based on a population of children like those eligible for EPSDT and it is useful only for a narrow age range.[23]

--Many of the people doing screening and counseling did not have adequate training to find children's developmental problems and to counsel families.

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[22] The bases for and further discussion of these findings are in Chapter 6.

[23] Preliminary analysis of an HEW survey shows that, of 38 states reporting, 27 use the DDST alone or with other tests to identify children with developmental problems. (Medical Services Administration, "Developmental Assessment in the EPSDT Program: Position Paper" (Washington,D.C.: Social Rehabilitation Service, HEW, 1976), p. 4).) For an evaluation of the DDST, see Oscar Krisen Buros, (ed.), *The Seventh Mental Measurements Yearbook*, (Highland Park, N.J.: Gryphon Press, 1972), pp. 733-735.

--Few places had treatment resources available in the numbers or kinds needed to help children identified as needing them. Furthermore, coordination with other federally-funded programs designed to serve children's developmental needs was minimal.

--In some places, the kinds of services and personnel covered under Medicaid impeded providing needed services to children with developmental problems.

--In some states, Medicaid policies encouraged screeners to label children by making a diagnosis on the basis of a screen.

5. EPSDT rarely linked children to an ongoing source of primary health care.[24]

Even if EPSDT were fully implemented it would not constitute comprehensive care for poor children. Targeted on screening and following up on conditions found during screening, EPSDT does not provide routine care for sore throats, earaches and other common childhood illnesses. However, EPSDT services *could* link poor children to a system of ongoing, comprehensive care by putting them in touch with or providing EPSDT services through comprehensive providers. Unfortunately, EPSDT's potential remains much greater than its performance. The reasons were several:

--Many states failed to use providers in their EPSDT programs that could offer ongoing, comprehensive care to children. Half of the states in the country elected to provide screening primarily through local health departments, which almost never had either the staff or the mandate to provide routine health care on a continuing basis. In fiscal 1975, these health departments accounted for over 58.8 percent of all screenings performed through EPSDT.

--In the remaining half of the states that allowed a variety of providers to do EPSDT screening--theoretically with greater potential to link children to continuing care--fewer children and a smaller proportion of eligible children were screened than in states using health departments. Programs using a variety of providers were more complex to administer and took longer to implement. Furthermore, various Medicaid policies such as low rates of reimbursement and failure to use certain qualified providers have discouraged or excluded many potential comprehensive care providers from participating in EPSDT and serving these children.

--Families were rarely told the range of options they could choose from in selecting a Medicaid provider for EPSDT screening or treatment, and they were rarely encouraged to use sources of ongoing health care. Nor were they referred at the time of screening or treatment to a source of regular health care if they did not already have one.

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[24] The bases for and further discussion of these findings are in Chapter 7.

6. Federal support and leadership in implementing EPSDT have been minimal. Federal enforcement has not been effective in assuring eligible children get the benefits to which they are entitled.[25]

Particularly given the ambitious nature of EPSDT, the states' lack of experience in mounting a program of its kind and the reluctance of some states to implement EPSDT fully, explicit program standards were vitally needed. Needed, too, were technical assistance, incentives and remedies capable of assuring that states complied with the law. HEW failed to provide adequate leadership, guidance or assistance. It did not set appropriate standards, review carefully states' performance or use effective sanctions to make sure EPSDT was implemented properly.

--Federal regulations were not issued until two-and-a-half years after EPSDT became effective. Even then, they defined the adequacy of states' programs by what steps states took toward compliance rather than by the extent to which children actually received services. As a result of the lack of specific outcome or performance-oriented criteria, during the first penalty review period, 20 states and territories were found to be in compliance even though they performed fewer than one-third of the screenings they should have according to the AAP's standards.

--Because of the slowness of implementation, in 1972 Congress enacted a penalty for noncompliance: 1 percent of the federal share of a state's AFDC funds. Although the EPSDT penalty requirements were clearly meant to supplement and not to replace broader requirements of the program, the existence of two sets of program requirements led to confusion. States have interpreted their obligation as having to comply with the far narrower penalty requirements; HEW has not taken steps to enforce the broader regulations. The result is that certain requirements essential to EPSDT's implementation (such as informing *all* eligible children about EPSDT and using all existing qualified providers) frequently are not met.

--Federal enforcement has not been vigorous. HEW has completed penalty reviews only through September 1975. And although HEW has found 9 states out of compliance with EPSDT requirements, to date no funds have been withheld.

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[25] Further discussion of these findings is in Chapter 2.

Why Should We Care About Improving EPSDT?

Given this less than impressive record of achievement, why do we care about EPSDT? Why not eliminate it? Chalk it up as a bad experiment and reallocate the money spent on it? We know that the Medicaid system with its inherent imperfections will never reach all needy children, ensure quality care, contain costs or eliminate a two-track system that results in second-class care for the poor. Why tinker with this small piece of it, then?

There are two important reasons. The first is that the millions of poor children who need better and more accessible health services now can be helped by relatively simple improvements in the EPSDT program. According to projections by the Congressional Budget Office, among Medicaid-eligible children, 3,200,000 need immunizations, 2,184,000 need treatment for anemia, and 2,210,000 need care for vision or hearing impairments.[26] An improved EPSDT program can realistically be expected to do much toward meeting these and other pressing health needs.

And *while we are convinced that the only way poor children will receive truly effective health care is through a national health insurance program designed to assure comprehensive care to all Americans, it is clear that poor children's health needs cannot go unmet until such a program is enacted.* Experts agree that even if national health insurance legislation were introduced immediately, it would be at least four years until services became available because of the time required to legislate, plan and implement a major new program.

In the meantime, there is no other federal health program which can be built on with an equally rapid and widespread payoff for poor children. The other major federally-financed health programs for children--including Community Health Centers, comprehensive programs under Title V, and Migrant and Indian Health programs--have been effective and we support their expansion. However, it is unrealistic to expect them to gear up during the next year or two to meet the needs of the millions of children who do not now have access to their services. In 1975, these programs were estimated by HEW to have reached 1.7 million children.[27] This compares to an estimated 13 million children certified for Medicaid. While new resources are being developed through expansions of these programs, the more rapid reforms that can be made in EPSDT will result in improved services for poor children. Thus, we do not hesitate to recommend an increased investment in EPSDT, despite our clear awareness of its limitations.

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[26] Task Force on Human Resources, Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," p. 128.

[27] Office of Child Health Affairs, "A Proposal for New Federal Leadership in Maternal and Child Health Care in the United States" (Washington, D.C.: Office of the Assistant Secretary for Health, HEW, November 1, 1976), p. 31.

The second reason to improve EPSDT now is that, in the process of making EPSDT function more effectively, we will confront and help to resolve some of the key problems that any program of national health insurance will have to address in order to be effective. If we are not to duplicate the mistakes of wasteful, piecemeal and inadequate health care programs of the past, we must (a) develop effective ways to reach out to families currently outside the health care system; (b) establish standards for complete, quality care and methods to monitor and enforce these standards; (c) involve more doctors and clinics as providers in publicly-financed programs; and (d) provide incentives to develop health resources where they currently do not exist--in urban centers and remote rural areas.

EPSDT has already taught us valuable lessons for the design of an effective national health insurance program. (The Postscript at the end of this chapter describes the most important of these.) The reforms we recommend for the EPSDT program will strengthen the foundations on which a new universal program can be built.

Despite its slow and difficult beginning, EPSDT has benefited many children who otherwise would not have received basic health services. Much has been learned about how to improve it. *Therefore, we recommend that EPSDT reform be undertaken at once, at the same time as planning for national health insurance goes forward.* Because the overriding purpose of EPSDT reform is to bring more needed health care to poor children now, we do not recommend a total overhaul of EPSDT. Rather we recommend changes that can be implemented quickly and will bring immediate benefits to children. Below are our broad recommendations for EPSDT reform. Following each chapter are our more detailed recommendations, setting out the specific steps which must be taken by the Congress, HEW, state and local administering agencies, providers, health advocates and parents.

We recognize that many of our recommendations will not be easy to implement, and will require considerable will, creativity, cooperation and effort on the part of administrators, physicians and a range of others who work on behalf of children. Nevertheless, we believe these recommendations will move EPSDT in the direction of providing better health services to more children.

Major Recommendations

1. The focus of EPSDT should be shifted away from "screening" to a program providing regular, comprehensive health assessments to children eligible for Medicaid. The language in Title XIX to screen for "physical and mental defects" should be replaced by language requiring states to assure comprehensive, regular health assessments according to a child's needs. On the basis of consultation with health professionals and consumer groups, federal regulations should be issued defining what constitutes an assessment, the frequency with which children of various ages should be assessed and the procedures necessary at each visit.

2. Complete health services following an assessment should be provided. At a minimum, federal regulations should be amended to expand states' obligation to provide all health care indicated by an assessment and needed outpatient health services following an assessment. In addition, regulations should make explicit that where special educational and child development services are indicated by an assessment, states must at least arrange for them (as opposed to provide them directly).

3. Routine as well as emergency dental care should be provided as needed to children eligible for Medicaid. The existing regulation should be clarified to assure that any eligible child can receive needed dental care regardless of whether the child has received a dental screening or has been referred by a provider of an assessment.

4. There must be one clear set of regulations governing EPSDT. The original EPSDT regulations and the subsequent penalty regulations should be consolidated. The combined regulations should include explicit federal standards dealing with program performance, administration, and quality of care against which states' progress in implementing EPSDT can be measured.

Performance should be measured by criteria based on the extent to which services are provided to children. For example, outreach and the provision of assessments should be measured by comparing the number of children who receive assessments to the number who should have received them; treatment by the number of children who receive follow-up care compared to the number who need care, provider participation [illegible] the proportion of qualified providers who deliver EPSDT services.

In addition, specific procedures

should be mandated for informing, assessing and providing follow-up care, for assuring that the use of services is voluntary and for using qualified providers. (These are detailed in recommendations in Chapters 3-6.)

5. Maximum use must be made in EPSDT of all qualified providers. Title XIX should be amended to make the coverage of services provided in primary care clinics, which meet states' certification criteria, mandatory rather than optional. In addition, primary care services, when provided by physician extenders, nurses and paraprofessionals licensed in accordance with state law and working in organized clinic settings, should be reimbursed as clinic services.

Federal regulations should be revised to make explicit that states must use all qualified providers who want to participate in EPSDT for assessment and follow-up care (including community-based organizations such as neighborhood clinics and multi-service clinics) and must offer reasonable reimbursement rates for their services. In addition, HEW should enforce vigorously the existing Medicaid requirement that states establish reimbursement rates sufficient to assure that recipients have access to services to the same extent as do others in the community.

6. Congress should establish immediately a major program to develop needed resources for providing health assessments and needed primary care. Federal funds and technical assistance must be available to assist organized providers of limited services (e.g., screening programs) to expand their services so that children can receive assessments, routine treatment and other primary health services from the same provider. In addition, federal funds and assistance must be available to help communities develop *new* resources for providing general medical and specialty care where, due to scarcity, children currently are unable to receive services promptly.

7. Eligibility for Medicaid should be extended to individuals under age 21 who qualify on the basis of family income, and every child should remain eligible for Medicaid for at least one year following an assessment. Title XIX should be amended to require states to make eligible for Medicaid individuals under age 21 who meet the state's *financial* eligibility standard but not necessarily its other welfare requirements. In addition, Title XIX should be modified to allow any child who would otherwise lose eligibility to remain eligible for all Medicaid services for at least one year following an assessment.

8. EPSDT outreach must be strengthened considerably. In addition to maintaining the federal reimbursement arrangements for outreach services performed by public

agencies, there should be financial incentives for outreach to be done by private, nonprofit, community-based organizations (e.g., Head Start programs, community clinics). Title XIX should be amended to provide a national average of 90 percent federal reimbursement (the exact federal shares among the states would vary as they do now for medical services under Medicaid) for outreach services performed under contract by these organizations.

9. Developmental assessment should be performed within the context of the comprehensive health assessment. Federal regulations defining the assessment should not single out the developmental component. Rather, HEW should define, in consultation with professionals, administrators and consumer groups, how the comprehensive assessment should review selected aspects of children's development.

10. Every state's Medicaid plan should include a complete explanation of how EPSDT requirements will be carried out. There should be wide public participation in development of the EPSDT part of the plan. Title XIX should be amended to require that Medicaid state plans address how EPSDT provisions will be carried out (see, for example, recommendation 3 in Chapter 2 of this report) and that the planning process include meaningful public involvement. In addition, HEW should issue guidelines immediately, indicating those aspects of EPSDT programs for which states are encouraged to establish program development plans. The guidelines should identify important program features which have been most difficult to implement properly and should encourage states to set out steps to be taken during the year to address these problems.

11. Federal EPSDT reporting requirements should be revised to include: (a) services provided to children by the age groupings 0-3, 4-6, 7-12 and 13-21; (b) assessments according to whether they are initial, second, third or more; (c) more detailed breakdowns of the type of conditions found; and (d) information on whether and what treatment was provided to children for problems found in an assessment. Reports and state record keeping systems should collect and provide information on the basis of children (e.g., they should report the number of children screened and not number of screenings performed).

12. States and localities should receive financial assistance to improve the administration and program performance of EPSDT. Title XIX should be amended to increase the federal match to states for EPSDT administrative services, community-based outreach services, assessments and outpatient care following assessments to a national average of 90 percent (the exact federal shares among the states would vary as they do now for medi-

cal services under Medicaid). To assure that increased federal assistance leads to a strengthened EPSDT program, states must be required to maintain their current level of financial commitment.

13. At the state and county level, one person should be designated responsible for EPSDT. In addition, each state and county administrator should appoint a pediatric and a dental advisor whose job is to encourage cooperation and support of providers and to lend technical expertise to the program administrator.

14. Considerable technical assistance should be made available to states to improve EPSDT programs. HEW must increase immediately its capacity to provide technical assistance.

15. HEW must use a range of enforcement tools capable of assuring that EPSDT reaches its intended beneficiaries. HEW should conduct regular reviews of state compliance with EPSDT requirements by evaluating the adequacy of state plan material related to EPSDT and by making site visits to randomly selected counties in each state. As a supplement to the Secretary's authority to cut off a state's Medicaid funds, Title XIX should be amended to require the Secretary to use one of two remedies when, following the opportunity for an administrative hearing, violations in a state's EPSDT program are found. The Secretary should (1) have the authority to withhold 20 percent of the federal share of the state's administrative costs for the Medicaid program; and (2) have the authority to issue an order for the state to provide the requisite services. In the latter instance, the state should have a 30-day period during which to appeal the finding of noncompliance to a United States Court of Appeals. If the state does not appeal within 30 days or if the Court does not disagree with the Secretary's decision, then the order is enforceable through the courts. Strict timetables which guarantee that compliance reviews, citations for noncompliance, administrative hearings and consideration of appeals are carried out expeditiously must be established. These provisions should in no way interfere with the right of recipients to initiate private litigation to enforce their rights under the EPSDT program.

16. Parents and advocates must take an active role at the local, state and federal levels to plan EPSDT services and to monitor their implementation. EPSDT advocacy groups should be formed to carry out these functions as well as to help inform parents of their rights under the program and to help them use the EPSDT services to which their children are entitled.

Postscript: Lessons For the Design of National Health Insurance

The EPSDT experience is a rich one. It has provided new information about what health problems families bring to providers, how families use or do not use health services, what features of health care are crucial to its effectiveness and what policies and practices have failed dismally. It would be foolhardy to design a new program of national health insurance without drawing on the lessons EPSDT has taught us. Based on our review of the EPSDT experience, we are convinced that any program of national health insurance must have the following characteristics:

Eligibility for National Health Insurance Must Be Universal

EPSDT's--and Medicaid's--eligibility policies have taught us three things:

(1) Eligibility requirements based on criteria like income, employment or welfare status result in large numbers of people losing and regaining eligibility during the course of a year. On-again, off-again eligibility can never result in health services of high quality. Under these conditions, health providers are limited to providing episodic interventions; they are unable to establish continuing relationships with families; they cannot draw on accrued knowledge about their patients, their conditions, and the social and environmental circumstances of their lives; and they are hampered in educating families about the most effective use of services. Both providers and patients find health care delivered in this way inefficient and unacceptable. Many in both groups choose not to participate.

(2) Determining eligibility--especially when it is based on criteria that are complex or difficult to verify--is time-consuming and expensive. In EPSDT, welfare caseworkers spent so much time doing eligibility certification that there was almost no time or personnel left for adequate outreach, explanation about the program or provision of support services. This time-consuming task of determining eligibility eats up dollars better spent on services.

(3) Eligibility policies that restrict a program to poor people narrow the program's constituency and political base to such an extent that its ability to deliver effective health services is ultimately undermined. Witness EPSDT's record: no regulations issued for five years; crippling limits on staff in the federal office to administer the program; and continuing cutbacks in benefits. While vigorous national leadership supporting programs serving the poor may have had some short-run successes (as did the OEO programs of the mid-sixties), and while targeting re-

sources on the most needy may be a necessary interim step, programs for the poor alone will not work in the long run. Unless the participants in the program come from many strata in society, there is little assurance that the program will continue or that a double standard of services will not prevail, discriminating against the poor.

For all these reasons, eligibility for national health insurance should be universal. Nothing short of that will alleviate the two-track system Medicaid has engendered. If national health insurance is implemented in stages, the only acceptable way to phase in groups is to cover groups that are easily identifiable and whose status does not change frequently, such as all children under a given age. Neither income nor welfare nor employment status should be criteria for eligibility.

A National Health Insurance Program Must Cover Comprehensive Health Services, Including a Range of Health-Related Support Services

Children need comprehensive health services. EPSDT has shown conclusively that in order to deal effectively with children's health problems, a variety of services not typically included in conventional definitions of medical care must be provided. Iron deficiency anemia, parasites, learning difficulties--all commonly found in children through the EPSDT program--call, for example, for counseling; collaborative work among health providers, parents and other institutions caring for children; and putting families in touch with a variety of resources in the community to help solve problems related to their children's health. These health-related support services must be provided in close conjunction with needed medication or other medical procedures. For example, a physician can give iron supplements for anemia, but nutrition counseling may be necessary to prevent a recurrence of anemia. Similarly, while lead paint poisoning can be treated with medication, children will have high lead levels in their blood again unless the family's apartment can be rid of lead paint. A health program must have staff to help families find this needed help.

Attempts to short-cut the provision of comprehensive care have not worked in the past; nor is there reason to believe they will work in the future. EPSDT was based on the assumption that the nation could save money and that children could be well-served by providing targeted, limited services which had high payoffs for finding costly, crippling illnesses. This assumption has proven to be false. While screening and selected treatment services were, in theory, highly cost-effective, the difficulty of actually finding, identifying and ameliorating serious conditions within the constraints of a program that does not deal with all the health needs of a child has produced ineffectiveness and waste. Health professionals are ill-equipped at a one-time screening to discover any one of myriad conditions that reveal themselves over time. And families do not always want the services such as screening which professionals have labeled as important or cost-effective. They use providers who can respond to the health needs that the family considers important. The EPSDT experience has confirmed findings from other sources that providing a full range of health services is more effective than complicated computerized case management systems (coordinating a host of disparate services) to make sure children get the health care they need when they need it.[28]

A National Health Insurance Program Must Make Maximum Use of Providers of Comprehensive Care; Where Such Providers Do Not Exist, the Program Should Provide Incentives for Their Development

While EPSDT has demonstrated beyond doubt that children need comprehensive care, it has also shown that the professionals and arrangements to provide it are lacking in many communities. EPSDT has shown, too, that simply making money available to reimburse providers, as does Medicaid, does not encourage providers to expand the services they offer; nor does it create comprehensive services where they are needed. National health insurance must be designed to remedy these problems.

First, policies governing reimbursement levels and methods, certification of providers and reporting must be carefully designed to encourage all qualified providers to participate in the program. Policies must be not only reasonable, but consistent with one another. Currently, they often undermine each other. For instance, the National Health Service Corps attempts to attract qualified young physicians into rural areas, but Medicaid compensates them at a lower rate than young physicians starting in practice in the city; the federal government sponsors physician-extender clinics in isolated rural communities, but in most states, Medicaid will not reimburse for services provided by physician extenders; HEW and private foundations encourage the establishment of primary care clinics in health-deprived areas, but many of these clinics do not qualify for Medicaid reimbursement.

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[28] See, for example, evidence cited in *Doctors and Dollars Are Not Enough*, pp. 12-13 and 65.

Beyond underscoring the need to correct these sorts of problems, EPSDT has shown that in order for a sufficient number of providers to participate in the program, reimbursement rates must be competitive with going rates in the community. Otherwise, many providers simply will choose not to be involved, and beneficiaries will be left with too few providers or with an array of providers that does not match their needs.

Universal coverage would avoid these problems. But short of that, a federally-supported health insurance program must take steps to protect its beneficiaries from discrimination and scarcity. It should, for instance, require that physicians who participate in any federally-financed health program participate in all such programs (e.g., a physician could not participate in the federal employees health benefits program but not in Medicaid; or in Medicare but not in a health insurance program for all mothers and children). The federal government might also require that in return for the federal subsidy that is involved in educating medical students, when the students graduate, they have an obligation to take care of patients whose bills are paid from a federally-supported health insurance program.

But even if all or most existing qualified providers participated in the program, there would still be a need to develop new and better sources of health care. The EPSDT experience has demonstrated that organized settings where health and related support services can be provided together are lacking in most places. It is difficult for physicians practicing alone to provide all the health services children need. Comprehensive care requires a variety of personnel working together--a mode of care that is not amply available. The EPSDT experience has also shown that not any source of care will do. Services often go unused unless providers are trusted and accepted by the families who rely on them. Organized programs must be located in the community to be served and have strong ties to the people they aim to reach.

The need for modifications in the health delivery system is clear. National health insurance must be designed to bring these changes about, and to support the operation of a system that has the capacity to deliver appropriate services. Therefore, national health insurance must develop resources in shortage areas, and it must develop the kinds of providers that EPSDT and other experience have shown to be effective. For example, there is much evidence that organized providers such as Neighborhood Health Centers, Children and Youth centers and some Health Maintenance Organizations have performed these functions well and should be replicated. In addition, smaller, low-technology primary care centers--attached to community programs such as child care centers which emphasize easy physical and psychological access--must be developed. Solo practitioners and other providers offering a narrow range of services should be able to obtain help in expanding the services they can deliver.

A major federal commitment is needed to assist professionals and consumer groups in local communities to establish and operate these organized programs. Specifically, this means:

- technical assistance and start-up funds for provider groups serving underserved areas;
- subsidies for health-related support services and for services designed to make health care accessible to people in underserved areas and to groups with special needs;
- the adoption of payment methods (including provisions to facilitate annual per capita payments and other alternatives to fee-for-service) which are simple to administer and which provide incentives for using the most appropriate services and personnel;
- suitable standards and methods of certifying providers and provider organizations, administered in ways that do not discriminate against any class of qualified providers or provider groups (be they physician assistants, nurse-midwives or neighborhood health centers).

National Health Insurance Should Include Periodic Screening as a Supplement to Comprehensive Care

As the EPSDT experience has shown, it has proven exceedingly cumbersome to build a program to meet major unmet health needs on the narrow foundation of screening. When children do not have access to ongoing, comprehensive health care, a program of screening and follow-up is a poor substitute. But given a comprehensive national health insurance program where children are assured access to continuing care, would there be a need or a useful role for screening? We believe there would.

Screening under such circumstances would be very different from that mandated by EPSDT. Selected tests such as those for anemia, vision or hearing problems would be performed at a few specified intervals: for example, once during infancy, once before entering elementary school and once before entering junior high school. Such screening would provide a check on the adequacy of the care being provided to children and would assure that at least those conditions which one-shot screening can reliably detect would not go unnoticed. In addition, screening for certain conditions such as anemia could identify children who still are outside the system of health care and could enable efforts to be made to link them to sources of continuing care.

There have been promising experiences abroad using screening as a *supplement* to comprehensive care (e.g., in Sweden). Health professionals and HEW, in consultation with consumer groups, should identify what screening tests can usefully be provided as a supplement to comprehensive care; at what stages of life they should be given; under what auspices; and how their findings could most effectively be used to assure the provision of necessary follow-up diagnostic and treatment services to link children to ongoing health care.

A National Health Insurance Program Must Assure That Outreach, Transportation, and Other Access Services Which Help People Make Effective and Timely Use of Primary Health Services Are Provided

The EPSDT experience documents again that removing financial barriers is not enough to make health care accessible. Even though Medicaid paid medical bills, too many eligible children did not get needed care because EPSDT failed to provide information, transportation and other kinds of needed assistance in ways families used. EPSDT has also shown that not every measure labeled "outreach" will do. Personal outreach, done by community members known and trusted by parents, clearly is the method that best achieves its goals.

In the past, many have thought that such services are frills. But the evidence continues to mount that, in fact, these services are indispensible to making health care accessible to those who most need it. National health insurance must include provisions for outreach and other access services such as transportation. At a minimum, national health insurance should make subsidies for these services available to qualified, organized providers (including primary care centers, community clinics, group practices, Health Maintenance Organizations and hosptial outpatient clinics) serving areas with large numbers of persons who need them. Legislative authority and a funding mechanism for such services must be explicit.

A National Health Insurance Program Must Take Measures to Assure That Reasonable Standards of Quality of Care Are Met

One of EPSDT's most vivid lessons is that minimum standards of quality are not met unless they are clearly stated, monitored and enforced. Children who were screened through EPSDT often received incomplete health assessments. Even states with good administrators, relatively prosperous economies and reasonable amounts of resources did not necessarily assure high quality services.

A national health insurance program must establish, monitor and enforce standards of care, especially in those areas of practice where optimal procedures are widely agreed upon within the medical profession. Without attention to these mechanisms, quality will be left unguarded, fraud or abuse will continue undisturbed and the inflationary trends in health care will soar well above our ability to pay.

Certain fundamental structural changes inherent in a national health insurance program would provide a considerably more propitious climate for upgrading quality of care. First, by including the entire spectrum of income groups in the society and giving the middle-class and the affluent a stake in how well the program is run, a national health insurance program will have taken the most important step toward safeguarding quality.[29]

Second, when such a program is enacted following widespread public interest and participation (which was not the case with EPSDT), citizen and professional pressures to improve and maintain quality tend to operate more effectively, leaving a smaller number of issues of quality to be dealt with through government enforcement mechanisms.

Third, to the extent that it encourages group practices and reimburses by methods other than fee-for-service, national health insurance will provide settings more conducive to the provision of quality care.[30]

And finally, ways must be developed through which the health system takes responsibility not only for those who come through the door seeking care, but also for those who fail to enter the system. Some existing programs, including HMO's and Neighborhood Health Centers, have demonstrated the feasibility of assuming responsibility for a defined population (defined either through enrollment or place of residence). Such a defined population makes possible monitoring and assessments of performance which can have an enormous positive impact on quality of care. This concept must, however, be expanded beyond isolated groups of persons who are linked to a certain provider or group of providers. It is only when mechanisms are developed through which everyone becomes part of a defined population for purposes of planning and accountability (if not for purposes of delivering services) that we will be able to assure that required health services are available and accessible for the entire population.[31]

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[29] Anne R. Somers and Herman M. Somers, "A New Framework for Health and Health Care Policies," *Inquiry* (June 1977) 14:2.

[30] Evidence of the advantageous effects on the quality of health care of group practice combined with capitation reimbursement can be found in the following studies: Sam Shapiro, Louis Weiner and Paul Dense, "Comparison of Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice, Medical Care Plan," *American Journal of Public Health*, Vol. 48 (February 1958), pp. 170-85; Mildred Morehead, Rose Donaldson and Mary Seravalli, "Comparisons between OEO Neighborhood Health Centers and Other Health Care Providers of Ratings of the Quality of Health Care," *American Journal of Public Health*, Vol. 61 (July 1971), pp. 1294-1306; Avedis Donabedian, "An Evaluation of Prepaid Group Practice," *Inquiry*, Vol. 6 (September 1969) pp. 3-27; Joy G. Cauffman and Milton I. Roemer, "The Impact of Health Insurance Coverage on Health Care of School Children," *Public Health Reports*, Vol. 82 (April 1967) pp. 323-328; Institute of Medicine, "HMO's: Toward a Fair Market Test," (Washington, D.C.: National Academy of Sciences, 1974), p. 52; Milton I. Roemer and William Shonick, "HMO Performance: The Recent Evidence," *Milbank Memorial Fund Quarterly* (Summer 1973), pp. 271-316. The last two of these studies also point out the hazards of underservicing in prepaid group practice, and emphasize the necessity of appropriate public monitoring to guard against new and different causes of diminished quality.

A National Health Insurance Program Must Provide More Than Financial Protection. It Must Include Strong Federal Leadership and Authority To Create and Maintain a Health System That Will Meet the Health Needs Of All American Families

Planners and administrators of a national health insurance program must demonstrate their commitment to a quality health care system. They must recognize that every decision about whether, how much, and under what circumstances to pay for a health service has a direct impact on whether and under what circumstances that service will be available. An exclusive preoccupation with narrow financial and cost considerations, without taking into account how people actually use health care, ultimately will lead to a program that will not be effective in helping children or saving money.

The goals of EPSDT were clearly compromised by an overemphasis on financing considerations which resulted in placing EPSDT in the context of welfare with all its eligibility requirements, its stigma of second-class services and its highly vulnerable constituency. Similarly, the health purposes of national health insurance can be subverted by an exclusive preoccupation with paying medical bills. A national health insurance program must do more than provide financial protection against the high costs of illness and remove financial barriers to needed care. For it to be effective, it must encourage and support the creation of a system of health services that will meet the needs of families who use the services. Since family members know best what kinds of services they will use, they should be included in the planning process.

The need is not to keep people

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[31] Rashi Fein, *A Right to Health* (New York: John Wiley and Sons, 1976).

away from the health system, and not a matter of narrowing the services offered or erecting barriers to their use. Rather, parents must be given the opportunity, the information and the support to function as collaborators with health professionals in maintaining and restoring health. The fundamental question that the EPSDT experience raises for planners of national health insurance is whether we can harness an increasingly complex health system to serve simple human needs, or whether we are going to let it get away from us to the point we are fast approaching--where we pay increasingly enormous sums of money for services that are less likely to meet the most fundamental needs of children and families.

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Chapter 2

Shortcomings in the Administration and Enforcement of EPSDT

Enacting a program into law is no guarantee that the mandated services get to the intended beneficiaries. A program's record is only as good as the way it is administered and enforced. Over the years, a considerable amount has been learned about what makes administration and enforcement effective: responsibility for the program must be clearly lodged with agencies capable of shouldering it; appropriate standards against which program performance can be measured must be set; ways to assist and to encourage program staff to meet these expectations must be developed; information to determine whether standards are met must be collected; and steps to assure an adequate level of quality in services across the country must be taken. How does the administration and enforcement of EPSDT compare with these principles?[1]

Neither the EPSDT legislation nor its legislative history specified how these important functions should be carried out. About the only thing that was clear was that Congress gave the Secretary of HEW responsibility to define and implement the program. Yet, despite HEW's clear authority and responsibility, the ten-year period between then and now has consisted of a series of delays and largely ineffectual moves by HEW to implement EPSDT. While several problems inherent in the program made it difficult to implement, inadequate performance by the states in areas where progress could have been made

[1] There are several thoughtful analyses of the problems involved with implementing and enforcing EPSDT: see, for example, Edward F. Shay, *Enforcement Problems in EPSDT, A Health Law Project Study* (Philadelphia, Pa.: Health Law Project, November 1974) (Mimeo); Anne-Marie Foltz, "The Development of Ambiguous Federal Policy: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" *Milbank Memorial Fund Quarterly* (Winter 1975); John K. Iglehart, "States' Child Care Record May Affect Agency's Insurance Role," *National Journal Reports* (June 29,1974), pp. 969-974; and Gilbert Y. Steiner, *The Children's Cause* (Washington, D.C.: The Brookings Institution, 1976), pp. 221-239.

was allowed to continue because of the weak enforcement posture of HEW.

Exactly what steps have several Secretaries and their subordinates taken to implement and enforce the provisions of EPSDT since its enactment? What progress has been made by the states?

A Chronology

Date	Congressional or Federal Action	Progress in Implementing EPSDT in the States
December 15, 1967	Congress passes the law establishing EPSDT.	
January 2, 1968	President Johnson signs EPSDT into law, to be effective July 1, 1969.	
July 1, 1969	HEW publishes "basic regulations." These simply repeat the vague language of the statute, giving HEW no concrete requirements to enforce and giving states no real guidance. Until final regulations are published, states are considered complying with EPSDT requirements if state Medicaid officials indicate in the state plan that they will carry out program requirements once further regulations are established.	
End of 1969		Two years after the law's enactment and 6 months after its effective date, no more than five states are reported to be screening children.
December 11, 1970	HEW publishes proposed regulations which elaborate on the "basic regulations." The public is given a 30-day comment period, after which HEW is to issue final regulations.	
October 1971	After almost a year's delay in publishing proposed regulations and after many meetings to try to prod HEW to issue them, the National Welfare Rights Organization, represented by the Washington Research Project (the parent organization of the	

Date	Congressional or Federal Action	Progress in Implementing EPSDT in the States
October 1971 (Cont'd)	Children's Defense Fund) and the National Health Law Program, files a lawsuit calling for publication of final EPSDT regulations.	
November 9, 1971	HEW issues final regulations, to become effective February 7, 1972, two-and-a-half years after the effective date of the law. Under severe pressure from the states, these regulations limit required treatment services to only those otherwise covered by the state's Medicaid program, plus treatment for vision, hearing and dental problems.	
December 22, 1971	Under continuing pressure to explain the regulations further, HEW publishes "Interim" Guidelines for EPSDT, to be effective February 7, 1972. These give states an additional year and a half--until July 1, 1973--to provide EPSDT services to *all* age groups of eligible children (as of February 7, 1972, states need screen *only* children up to age 6 years).	
January 1972	HEW begins monitoring EPSDT compliance. Essentially, EPSDT enforcement becomes part of the regular compliance program conducted by SRS.[2] States' failure to implement EPSDT is to lead to a cutoff of all Medicaid funds.	

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[2] The SRS compliance program assures that state plans and practices for welfare programs comply with federal requirements. Its main purpose is to detect technical violations easily discovered--on the basis of state plan material or reports about state practices which lend themselves to a simple determination of whether or not they are in compliance. Under the system, each quarter, staff in HEW's ten regional offices prepare a short report identifying regulatory requirements for which there may be a violation--for example: Do state requirements for eligibility meet federal requirements? Is there a State Medical Advisory Committee?

To determine compliance, SRS uses a "preprint": a form which lists Medicaid provisions with which states are expected to comply. A staff person from the regional office checks off whether or not the state meets the requirement. If there are questions of compliance, regional office staff must "clarify the situation and get the facts promptly..." and notify the state about the questions. (See, *SRS Compliance Manual* (Washington, D.C.: HEW, August 1971), Chapter II, p. 6.)

Date	Congressional or Federal Action	Progress in Implementing EPSDT in the States
February 7, 1972		Nine states are known to have an operating EPSDT program. Fifteen states have submitted Medicaid plan amendments, stating they are in compliance with EPSDT requirements. SRS reviews indicate that 34 of the 45 states on which compliance reviews were conducted were out of compliance. For the first four calendar quarters after EPSDT regulations became effective, 41 states are cited for noncompliance. In only one was a hearing recommended, and no further action was taken.[3]
March 23, 1972	HEW Secretary Richardson writes a letter to Senator Mondale saying that HEW lacks information to determine whether eligible children are receiving EPSDT services.	
April 1972	The Senate Finance Committee, concerned about the cost of implementing EPSDT, proposes provisions which would give states additional time to implement EPSDT fully.	
June 1972	The Congressional Black Caucus holds hearings on "Government Lawlessness," including failure to implement EPSDT.	
June 28, 1972	HEW issues "Final" EPSDT Guidelines which have far more detail than the "Interim" Guidelines.	
July 1972 - June 1973		500,000 screenings have been performed nationwide.

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2 (Cont'd)

After a maximum of six months of negotiations, the Commissioner in the HEW regional office is required to recommend to the Administrator of SRS that a formal compliance hearing be initiated, or, alternatively, to file a memorandum justifying why the Administrator should not initiate formal proceedings. If HEW finds a state out of compliance after a hearing, it has the authority to cut off all Medicaid funds.

[3] Memorandum from the Legal Committee of the National Welfare Rights Organization to Honorable Caspar Weinberger, Secretary of the Department of Health, Education and Welfare, "EPSDT of Medicaid Eligible Children," 30 March 1973.

Date	Congressional or Federal Action	Progress in Implementing EPSDT in the States
August 9, 1972	HEW initiates use of status reports (first serious attempt to collect information on the operation of states' EPSDT programs).	
October 1972	HEW begins collecting monthly statistics from states on the number of children screened and referred for various health problems.	
October 1, 1972		HEW compliance reviews find 43 states out of compliance with at least one EPSDT requirement. No funds are withheld.
October 30, 1972	In response to continued failure to implement EPSDT, Congress enacts the EPSDT penalty provision. Effective June 30, 1974, states are to be taxed 1 percent of the federal share of AFDC payments for failure to: inform AFDC eligible children at least once annually and in writing about EPSDT; assure that screening is available within 60 days of a request; and arrange for necessary treatment normally within 60 days of the time of screening. These "penalty requirements" supplement the obligations states have under the regulations issued in November 1971.	
November 10, 1972	HEW requires that each state not in compliance with EPSDT requirements submit a plan, by December 15, explaining how services will be made available by no later than February 1, 1973.	
July 1973 - June 1974		1.3 million screenings performed nationwide out of 6.5 million screenings that should have been done among the 9.75 million eligible children this year.[4]
December 19, 1973	HEW publishes proposed regulations for EPSDT penalty provisions.	

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[4] For an explanation of how these numbers were derived, see Appendix H.

Date	Congressional or Federal Action	Progress in Implementing EPSDT in the States
June 30, 1974	HEW begins quarterly reviews of states' programs to determine compliance with EPSDT requirements established by the penalty provision. For each subsequent quarter, regional office staff are to conduct reviews of the adequacy of states' programs.[5]	
July 1974 - June 1975		1.5 million screenings performed nationwide out of 6.65 million screenings that should have been done among the 9.98 million eligible children this year.
January 9, 1975		The General Accounting Office (Comptroller General of the United States) issues report citing delays in implementing EPSDT.
June 2, 1975	HEW cites seven states (Indiana, Montana, North Dakota, Hawaii, Minnesota, New Mexico, Pennsylvania) for noncompliance with EPSDT penalty requirements for the quarter ending September 30, 1974. In July, California is added to the list, and in October, New York is cited for noncompliance. (States have appealed these decisions and, to date, no funds have been withheld.)	
June 1975 - July 1976		1.7 million screenings performed nationwide, out of 6.85 million screenings that should have been done among 10.3 million eligible children this year.

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[5] "Penalty reviews" of each state's program are conducted by regional office staff each quarter. A review consists of a description of how the state fulfills the penalty requirements for informing, screening and treating eligible children and a small sampling of case records in six randomly selected sites in the state to determine whether the requirements for the prompt provision of screening and treatment services have been met for eligible children. Based on penalty reviews, the Secretary of HEW cites states found to be out of compliance. Before the 1 percent tax can be withheld, states may request reconsideration: a formal, legal process spelled out in regulation (45 C.F.R. §201.14).

Date	Congressional or Federal Action	Progress in Implementing EPSDT in the States
August 20, 1975	HEW proposes a second set of regulations to clarify states' obligations in complying with requirements of EPSDT's penalty provisions. To date, final regulations have not been issued.	
October 7-8, 1975	The House Subcommittee on Oversight and Investigation holds hearings on child health, with specific sessions on EPSDT, calling attention to failure by the states and HEW to implement EPSDT.	
January 12, 1976	Pennsylvania is cited as out of compliance with EPSDT penalty requirements for quarter ending December 31, 1974. On July 7, 1976, Hawaii is cited as out of compliance; and on December 14, 1976, HEW cites four more states (California, New Mexico, Indiana, New York) for noncompliance with EPSDT penalty requirements for the same quarter. No funds have been withheld yet.	
February 20, 1976	HEW revises procedures for penalty reviews to require that they be done every two quarters for states which are found in compliance during the past quarter. For states found out of compliance, penalty reviews are to be conducted each subsequent quarter.	

This chronology shows that more than four years after the program's enactment, and more than two years after its effective date of implementation, HEW had not promulgated regulations so critical in guiding states to begin EPSDT programs. Final regulations and guidelines eventually were published, but they deferred requiring full implementation for yet another year and a half. HEW did not conduct reviews of state programs until two-and-one-half years after EPSDT's effective date. Once having conducted such reviews, HEW failed to act on its findings. And to date, HEW has not issued final regulations to clarify states' obligations in complying with the requirements of EPSDT's penalty provisions.

What does this history teach us, both about improving the EPSDT program and about designing and implementing other child health programs?

Problems of Implementation

A Difficult Charge

The shortcomings in what EPSDT has accomplished can be explained at least in part by the difficulty of carrying out its extremely ambitious charge. A coherent child health delivery system across the nation was needed to provide the required outreach, screening, diagnosis and treatment. Yet in most places such a system did not and still does not exist. Certainly there were many disjointed health resources which some children could use, but they were not evenly distributed; many were not of sufficient quality; and in some places they simply did not exist. Even where they did exist they were rarely pieced together into an organized set of services that could provide ongoing primary health care.

In addition, EPSDT's mandate was to go beyond Medicaid's traditional role of paying the bills for health care, to the far more challenging role of assuring that children received the program's services. Assuring the receipt of health services--by helping families to understand the value of the services and by assisting them to get care--had never before been attempted for any large group of Americans and still has not been attempted for any other group.

Finally, when EPSDT was enacted, there had been little prior experience in this country with how best to screen and treat children on a large scale. Even in the medical profession, relatively little work had been done to define what constituted adequate screening for children and through what kinds of providers it was best performed. Nor was there sufficient information on the nature or extent of treatment which the program would have to provide--neither the kinds of health problems that would be discovered nor the kinds of services needed to deal with them. The estimates of the planners of EPSDT--that 12 percent of children would need follow-up care and treatment--has proven to be a gross underestimate, as has been the assumption that there would be enough health care resources to deal with them.[6]

Clearly, the problems confronting the administrators of EPSDT were extraordinarily different, in kind and in magnitude, from those which federal and state government had ever dealt with in the area of health care for children.

[6] "Maternal and Child Health Care Programs," (Washington, D.C.: Office of the Assistant Secretary for Program Coordination, HEW, October 1966), p. III. 24.

Administering EPSDT As Part of Medicaid

Given EPSDT's demanding charge, implementing the program was bound to be difficult. But HEW's decision to locate responsibility for EPSDT in SRS, the agency administering Medicaid, added to the problems.[7] First, it tied eligibility for EPSDT to Medicaid eligibility, thereby bringing to EPSDT all the problems of welfare certification and turnover in eligibility, thus limiting its ability to provide services to all needy children on a continuing basis. Second, the skills and interests required to launch a major new health care program did not exist in the SRS welfare bureaucracy, either at the federal, regional or state levels. Traditionally, staff in Medicaid agencies certified recipients as eligible and paid providers for services given to recipients. Staff of Medicaid agencies had never been in the business nor were they trained to design health delivery systems, define or assure the quality of services, or seek out needy recipients. In fact, in most places, the pressures on them were to keep costs down by limiting the number of recipients participating and the services to which they were entitled--an approach incompatible with carrying out EPSDT properly.

Third, the placement of EPSDT in Medicaid meant that although the program required a health delivery system that did not exist in many places, EPSDT was limited in its ability to create the necessary services. As a program which simply reimbursed for services, Medicaid lacked the mechanism and incentives to promote the development of new providers where needed or to help organize the existing, fragmented network of providers into a system capable of assuring that children got comprehensive care.

Fourth, as a part of Medicaid, EPSDT became a shared federal-state program.[8] With 53 different, but financially hard-pressed states and territories designing and administering a radically new program, the only way to assure adequate levels of quality in programs across the country was for HEW to take a strong leadership role in setting standards and guidelines, providing technical assistance to states and enforcing standards. However, with the shared federal-state approach, states bore from 22 to 50 percent of the costs of EPSDT, and they had considerable stake in how EPSDT standards were defined and enforced.[9] Clearly, it was in states' financial interests to limit the scope of the program--to cover a narrow range of services and to proceed slowly to screen, diagnose and treat eligible children.[10]

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[7] Because the EPSDT legislation amended both Title V and XIX programs, and because each is administered by a different agency, each agency potentially could have had a role in administering EPSDT. The Public Health Service (PHS) was the logical choice to assume the lead role. Traditionally, it had been the health care delivery arm in HEW. In addition, in 1967, the Title V program was transferred from the Children's Bureau to the Public Health Service. Because most of the other federal health programs affecting children were there also, placing EPSDT in the PHS would have created a single administrative locus in HEW for child health services. However, for reasons related mainly to securing appropriations for EPSDT, the Social and Rehabilitative Service (SRS) assumed responsibility for administering EPSDT. For detailed discussion of how and why this came about, see, Shay, *Enforcement Problems in EPSDT, A Health Law Project Study;* Foltz, "The Development of Ambiguous Federal Policy: EPSDT;" and Foltz, "EPSDT: Lessons for National Health Insurance for Children," paper presented at Maternal and Child Health Section, American Public Health Association, 103rd Meeting, Chicago, Illinois, 16-20 November 1975. (Mimeo.)

Finally, from the standpoint of monitoring and enforcing standards, EPSDT was placed squarely in the compliance system SRS used for welfare programs. While there is no reason to believe that monitoring would have been more effective if EPSDT were administered by the Public Health Service,[11] as we will show, the SRS compliance system was particularly ill-suited for EPSDT enforcement.

[8] See the Introduction in this report, "Medicaid and EPSDT," for an explanation of how federal-state programs work.

[9] States were concerned with costs from the start. By 1969, when EPSDT was to be effective, it was clear that the Medicaid program entailed substantial new costs for states. Each mandatory Medicaid benefit--in this case EPSDT services--was seen for what it really was: a significant new expenditure for which states and localities must share the cost. Rapidly rising prices in medical care aggravated states' preoccupation with costs. Developments in the Medicaid program as a whole, in the period following 1969, reflected this cost consciousness. For example, one major reason for establishing the Task Force on Medicaid and Related Programs in 1969 (chaired by Walter McNerney) was to attempt to deal with the issue of containing costs under Medicaid. The same concern motivated a major policy shift in 1972: an amendment to Medicaid was passed which repealed a section of the original law requiring that states should expand Medicaid services to make them comprehensive 42 U.S.C. §1396b(e), repealed by P.L. 92-603 §230.

[10] See Shay, *Enforcement Problems in EPSDT, A Health Law Project Study*, pp. 12, 32 and following, for an excellent analysis of how cost considerations affected policy formulation for EPSDT and later for HEW's enforcement efforts.

[11] Although from a program point of view, EPSDT belonged with other health programs in the Public Health Service, from the standpoint of administration and enforcement, EPSDT is not likely to have fared better there. PHS has had a laissez-faire posture toward implementing and enforcing its programs and has relied almost exclusively on the good faith and initiative of state and county health agencies. Few federal standards have been established and the agency has monitored activities in the states to an extremely limited extent.

The experience of the PHS in administering formula-funded services under Title V of the Social Security Act is a case in point. State obligations are defined only in general terms (except for the special project grants which constitute just a part of Title V activities). The PHS has very little information about how the money is being spent, whether it meets

No Patrons and a Limited Constituency

EPSDT has never had a powerful "patron"--an influential supporter who would follow its progress carefully and ride herd on enforcement. The only real pressure to implement or enforce EPSDT has come from outside organizations representing EPSDT beneficiaries. In some cases, they organized to bring pressure on state officials. They acted as intermediaries between concerned groups and state and federal officials, and they negotiated for improvements in the program. They helped monitor EPSDT implementation and brought lawsuits when enforcement lagged.[12] In a few places, they actually helped develop services for eligible children. But these organizations were few and they represented poor people.[13] Without the added and broader political strength of other influential interest groups (such as the medical professions and organized labor), none of which became staunch advocates of EPSDT, outside advocacy to prod the government to do its job could have only a limited impact.

Nor was there concerted interest from Capitol Hill. As a small part of the Social Security Amendments of 1967, EPSDT received little Congressional or public attention prior to enactment. And since then, while modest concern in EPSDT has been demonstrated, it has not been an issue with which any member of Congress has been strongly identified or to which any member is fervently committed. A few members of Congress have sent letters of concern to HEW. (For example, Senators Mondale and Ribicoff and Congressmen Ryan and Obey expressed written concern to the Executive about delays in implementation or about administrative decisions.) Two sets of Congressional hearings which included EPSDT issues were

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the needs of the children it serves or whether it reaches those most in need. The limited information addressing these issues has been collected by outside sources and shows that an extremely small percent of the funds are used for providing services to children.

See, George Silver (Principal Investigator), et al., *Politics and Social Policy: Failures in Child Health Services* (New Haven, Conn.: Yale Health Policy Project, Yale University School of Medicine, August 1976); and Report by the Comptroller General of the United States to the Committee on Ways and Means, U.S. House of Representatives, *Maternal and Child Health Programs Authorized by Title V, Social Security Act*, Report #B-164031(3) (Washington, D.C.: Government Printing Office, June 23, 1972).

[12] EPSDT lawsuits have been filed in 15 states. For a listing of them, see Appendix C in this report.

[13] The major groups on the scene were the National Welfare Rights Organization, the National Health Law Program, and a number of local legal services programs and other advocacy groups, including the Children's Defense Fund. CDF will be preparing an advocates' manual on EPSDT following publication of this report.

held. The first, held in June 1972 by the Black Caucus, raised EPSDT failures as one example of the topic for the hearings, "Government Lawlessness." In October 1975, the House Subcommittee on Oversight and Investigations looked at EPSDT in its hearings which focused on "Getting Ready for National Health Insurance: Shortchanging Children."[14]

While the hearings raised important questions about the lack of progress of implementation, they did not expose certain serious issues related to the administration of EPSDT and crucial program policies, such as: the adequacy of existing numbers of staff in HEW and in state Medicaid agencies to administer the program properly; the effectiveness of outreach efforts used by EPSDT; the maximum use of qualified health providers; assurances that the screens provided were complete; financial support for non-physician personnel who could provide important components of screening and treatment; and problems of securing transportation to needed care. And in the face of HEW's reluctance and the states' resistance to implement EPSDT, an intensive amount of negotiation and follow-up by Congressional staff was needed in order for these hearings to have an impact. That level of staff commitment was not made.

Federal Monitoring and Enforcement of EPSDT

Vigorous federal leadership and enforcement, important for any federal program, were absolutely critical given the difficulties and disincentives built into EPSDT implementation. Even so, federal enforcement efforts have not stacked up well against what was needed. The findings reported in Chapters 3 through 7 attest to the consequences.

Explicit, Unified Standards

Particularly given the ambitious nature of EPSDT and states' lack of experience in mounting a program like it, states needed guidance immediately after the program was enacted to be prepared to implement it. Standards were necessary to inform states of their responsibilities and recipients of their rights under the law, and to set benchmarks against which states' performance could be gauged. But as the chronology above shows, HEW was extremely slow in developing standards.

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[14] See Hearings, U.S. House of Representatives, Subcommittee on Oversight and Investigations, 7-8 October 1975 (Washington, D.C.: U.S. Government Printing Office, Serial No. 97-43, 1975).

Once established, the regulations of 1972 proved not to be explicit enough to assure that services across the country were of adequate quality. They failed to define what services constituted an adequate screen or adequate outreach. The EPSDT guidelines were far more explicit, but, by and large, the guidelines have not been enforced as program requirements.

The situation grew worse when a new set of requirements was included in legislation, passed in 1972, that established a financial penalty for noncompliance. This new law and its regulations defined what would trigger the penalty. Penalty regulations were clearly meant to *supplement* and *not to replace* the EPSDT requirements established earlier.[15] But having two sets of program requirements added to the confusion about exactly what was required. States interpreted their obligation as havto comply only with the penalty requirements. HEW has not yet taken steps to enforce the broader program regulations.[16] Far narrower in scope, compliance with only the penalty requirements meant that other important standards needed to carry out EPSDT frequently were not met or enforced.

In addition, the penalty requirements lacked clarity and specificity. States did not understand their precise responsibilities and HEW has had difficulty holding them accountable to certain requirements. HEW's General Counsel's Office has stalled on enforcement, arguing that the regulations are too vague to administer. The regulations, for example, require that treatment be available normally within 60 days of screening, but "normally" has not been defined.[17] HEW has proposed revised regulations to clarify certain issues but, to date, it has not published final, revised regulations.

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[15] *Bond v. Stanton* upheld that the penalty provisions were to supplement other EPSDT requirements. 504 F.2d 1246, 7th Circuit, 1974.

[16] An SRS official told us that there is tacit agreement in HEW to pursue compliance questions through EPSDT penalty procedures, not SRS compliance procedures. The result is that only the penalty requirements are monitored closely. This decision was made because the EPSDT penalty approach provided a far more rigorous review of state programs and had a remedy which HEW was more likely to apply (1 percent tax of the federal share of AFDC funds as opposed to a cutoff of all Medicaid funds).

[17] Similarly, General Counsel claimed that the requirement for states to assure screening and treatment within 60 days of a request (45 C.F.R. §205.146(c)(ii)(B) and (iii)(B)) meant states must only *assist* recipients to get services and did not mean that states must assure them or even determine whether or not services were received. Thus, General Counsel is arguing now that HEW can enforce only the "assistance" aspect of the requirement.

Aside from the vagueness of both sets of standards and the ambiguous relationship between them, neither set of EPSDT requirements used criteria that measured whether children were getting needed screening and treatment. Instead of defining the adequacy of state programs by the extent to which children actually received services, the regulations required only that states take certain steps (e.g., inform families about the program at least once annually in writing; provide screening within 60 days of a request) which may or may not result in children receiving health services. Thus, based on these standards, a federal judge found New York City's program adequate, even though it screened between only 6 and 14 percent of the City's approximately 750,000 eligible children. Only approximately 3 percent of children over age 6 had received screening services, and an unknown portion had received follow-up care.[18] Similarly, during the first penalty review period, 20 states and territories--performing fewer than *one-third* the screens needed by eligible children during a year --were found by HEW to be complying with EPSDT standards.[19]

Reviewing the Adequacy of States' Programs

In order to assure that states comply with EPSDT requirements, HEW needs considerable information about how the program operates, as well as legal documents--such as a state plan--which demonstrate compliance. It has never collected or required either.

Beginning in 1972, HEW added the EPSDT requirements to the list of compliance issues to be reviewed by SRS.[20] Essentially this meant that the enforcement of EPSDT became part of the regular SRS compliance system which reviewed the adequacy of states' welfare programs. For a program as ambitious and as complicated as EPSDT, this was a most inappropriate enforcement approach. Unlike requirements with which states must comply in other welfare programs, EPSDT requirements do not lend themselves to a simple determination (on the basis of state plan material or reports about state practices) of whether or not the state is in compliance. For example, determining whether states are fulfilling their obligation to make screening services available requires considerable information about steps taken by states to arrange for screening and about how many children are served. A box checked "yes" or "no" by staff in HEW's regional offices, with no supporting documentation, cannot accurately indicate whether states' are meeting screening requirements. For the first compliance review, 9 of 15 states found in compliance had not submitted any concrete evidence to show their program was in operation.[21]

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[18] See *Woodruff v. Lavine*, 399 F. Supp. 1008 (S.D.N.Y. 1975); opinion reported at 417 F.Supp. 824 (1976).

[19] These states were screening at a rate of fewer than 20 screenings per 100 eligible children; compared to the standard set by the American Academy of Pediatrics (66.7 screens per 100), these rates result in less than one-third of the needed screens. See Appendix H for these calculations and Chapter 4 for more on this subject.

[20] EPSDT requirements in 45 C.F.R §249.10(a)(3) were added to the list of SRS compliance issues.

Late in 1972, HEW supplemented this meager review process with measures aimed at addressing the special problems of implementing EPSDT. For the first time(but over three years after EPSDT's effective date), HEW began collecting descriptive information intended to let staff in its Washington, D.C. and regional offices know how states carried out EPSDT provisions. These EPSDT reports were the basis on which SRS could make technical assistance available to the states and could work with states to bring programs into compliance.[22] SRS also began collecting EPSDT statistics on the numbers of children screened and referred each month in each state. These statistics provided far more information than was previously available to judge the adequacy of states' programs, yet the data collected suffered from serious flaws.[23] Although this information was used by HEW to spot what aspects of programs called for technical assistance, it was not used as the basis for judging compliance with EPSDT requirements. In fact, not until July 1974 was the information from SRS compliance reviews supplemented with other information to determine whether states were complying with EPSDT requirements.

In July 1974, when the requirements of the penalty statute took effect, the review process became more rigorous. "Penalty reviews" of each state's program were conducted on a quarterly basis by staff in HEW's regional offices.[24] While the penalty reviews included far more information than was previously collected, they left several of the most important program requirements essentially unmonitored (e.g., making maximum use of existing providers and informing all eligible families of EPSDT services).[25]

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[21] "Child Health Care--HEW's Failure to Provide Screening, Diagnosis and Treatment of Indigent Children as Required by Federal Law," Statement of the National Welfare Rights Organization before the Congressional Black Caucus' Hearings on "Government Lawlessness," (Washington, D.C.: National Welfare Rights Organization, May 28, 1972), p. 7.

[22] For example, in November 1972, SRS required that each state not in compliance--at the time, 43 states were out of compliance--submit a plan explaining how EPSDT services would be made available by February 1, 1973.

[23] See Appendices F, J and K for more discussion of problems with EPSDT data.

Furthermore, the penalty reviews have been conducted with uneven accuracy and thoroughness across the country. There is wide variation among HEW's ten regional offices. We have been told that in some cases information provided by regional office staff does not accurately reflect what is going on, and it is doubtful that record samples have been conducted randomly in each of the states, as required. The quality of penalty reviews varies according to how much support EPSDT has from the Administrator of the regional office, the number of staff who work on EPSDT, the staff's interest in EPSDT and their competence in administration and enforcement, and the extent to which the regional office staff are willing to make objective judgments of states' performance, independent of pressures from interest groups and officials in the states.

Incentives and Penalties

To achieve compliance with program standards, there must be incentives for states to meet the standards as well as remedies capable of eliciting compliance when states fail to do so. Where remedies are necessary, they must be applied promptly.

Professional standards and personal commitment to serving children are the strongest incentives for states to implement EPSDT. There are no financial inducements. Medicaid is structured so that states save money by not pushing hard to make EPSDT services available. And states have not received encouragement in the form of technical assistance from HEW. Inadequate numbers of staff in the Washington D.C. and regional offices have meant that nearly all available staff are occupied by penalty reviews and other administrative tasks. Little or no time has been left to give thoughtful policy guidance and technical assistance to states. For instance, in 1974 there were only seven professional staff members in HEW's Washington EPSDT office. In each of HEW's ten regional offices, an average of one staff member was assigned to work on EPSDT.[26] Since then, there have been increases, but staff is still inadequate. In 1976, the Congressional Budget Office reported:

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[24] For a description of what constitutes a penalty review, see, again, footnote 5 in this Chapter.

[25] There have been several problems in determining compliance on the basis of information from the penalty reviews. First, some states do not record the date families request screening, so it is difficult or impossible to discover whether screening has been provided within 60 days of a request as required by law. Second, due to vague language in the penalty requirements, it is difficult to determine whether needed treatment is provided sufficiently promptly. The regulations require that treatment *normally* be begun within 60 days of screening. While the penalty reviews do indicate how many children have not begun needed treatment within 60 days of screening, HEW's General Counsel has had difficulty deciding whether the results satisfy the "normally" criterion.

> HEW's official commitment to EPSDT is for the equivalent of 33 full-time staff members in the central office and 56 in the regional offices. However, the program has little control over regional office employees so that staff members may devote considerably less than the allocated time to EPSDT.[27]

HEW had no incentives at its disposal to encourage EPSDT compliance, and it had few effective penalties to use when states were recalcitrant. And, as the enforcement history of EPSDT shows, those penalties that were available to the Secretary were not appropriate; nor were they vigorously applied.

Until the enactment of the EPSDT penalty statute, the only remedy for noncompliance was a total cutoff of states' Medicaid funds. This remedy has never been used for EPSDT noncompliance, nor for any other infraction in states' Medicaid programs. In the first four calendar quarters in which EPSDT compliance reviews were conducted, 41 states were found by HEW to be out of compliance with EPSDT requirements. In only one of these was a hearing recommended and, in that one like all the others, no further action has ever been taken.

The EPSDT penalty provision gave the Secretary the additional enforcement tool of withholding 1 percent of a state's federal share of AFDC funds if it was out of compliance with EPSDT. But, this penalty, too, has proved less than an effective remedy.

For some states, the remedy is less of a financial burden than is compliance with EPSDT program requirements. For 5 of the 9 states found out of compliance during the first penalty period, the amount of the penalty was less than $80,000, and for 3 of those states, the penalty amounted to $30,000. Furthermore, nothing currently prevents states so penalized from avoiding the burden altogether by passing it on to recipients in the form of cutbacks in eligibility or benefits.

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[26] Iglehart, "Health Report," pp. 969-970.

[27] Task Force on Human Resources, Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid under EPSDT," *Working Papers on Major Budget and Program Issues in Selected Health Programs* (Washington, D.C.: Committee on the Budget, U.S. House of Representatives, December 10, 1976), p. 124.

As with other EPSDT enforcement activities by HEW, the penalty requirements have not been aggressively pursued. HEW's process for reviewing the adequacy of states' programs and for allowing states to appeal HEW's findings of noncompliance has taken literally years. Not until nine months after the end of the first penalty period (in 1974) did HEW cite seven states for EPSDT noncompliance. To date, HEW has completed penalty reviews only through the end of the first quarter of fiscal year 1975 (July to September 1974).

As a result of the extremely time-consuming process of review and reconsideration, states found out of compliance in the fall of 1974 still have not been taxed the 1 percent penalty. "The states have thus received the message that penalties, if applied at all, will be applied so slowly that they may not be a threat." [28]

The Courts: Enforcement's Last Resort

Perhaps the strongest commentary on federal enforcement failures is that in many states, the courts have been relied on to enforce EPSDT. Since 1972, EPSDT lawsuits have been filed in fifteen states challenging a range of deficiencies related to outreach, the content of screening packages, periodic rescreening, assistance in obtaining screening and treatment services, availability of facilities and personnel, statewideness and referral to treatment.[29]

The majority of the cases are still pending, but some already have had pronounced impact.[30] Health lawyers have gained access to a wealth of information clarifying the status and deficiencies of the EPSDT program, and have negotiated on behalf of eligible children for needed changes. Frequently, negotiations have led to concrete improvements: increases in the number of providers used in the program (e.g., in Connecticut, the state increased the number of EPSDT providers from 14 to 157); development and dissemination of state policy on a number of unresolved issues (e.g., as a result of a suit in Maine, the state established procedures to determine which children are eligible for orthodontic treatment and under what circumstances); regular collection of data needed for program management (the extensive EPSDT data available from Pennsylvania's program resulted, in part, from pressures by attorneys suing the state); and development of policies which better meet the needs of recipients (e.g., in Michigan, transportation services were made available to families to get to providers of treatment as well as to providers of screening).

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[28] Foltz, "EPSDT: Lessons for National Health Insurance for Children," p. 20.

[29] See Appendix C for a summary of cases filed and persons to contact for further information on each.

[30] For detailed discussion of the impact of litigation in two states, see Eric Peterson, *Legal Challenges to Bureaucratic Discretion: The Influence of Lawsuits on Implementation of EPSDT*, Working Paper No. 27 (New Haven, Conn.: Health Policy Project, Yale University School of Medicine, April 1975).

However, now that nearly every state has some EPSDT program (e.g., even though there may be few EPSDT services being provided, the state has a set of policies and procedures and data suggesting that children are getting screened), achieving improvements through litigation is more difficult. The EPSDT lawsuit in Indiana illustrates why.

When the suit was filed in July 1973, the state had EPSDT programs in only 6 of 92 counties. At that point, noncompliance was clear, and the district court issued an injunction, later affirmed by the circuit court, requiring the state to develop a plan for implementing EPSDT. The order, however, was not explicit about what would constitute an *acceptable* plan. The state filed one and, despite several major inadequacies in the state's program (e.g., lack of a system capable of tracking recipients through the EPSDT process, lack of a specified screening package), the district court subsequently found the state plan to be in compliance with federal law.[31]

The EPSDT suit in New York City, mentioned earlier in this chapter, encountered a similar problem. In the face of no standards defining adequacy, and the City's proof that it was doing *something*, the judge found New York City's program to be complying with the law, despite the documented inadequacy of the City's EPSDT program.

Several factors account for the growing difficulty of using the courts for EPSDT enforcement. First, EPSDT law does not include standards of adequacy. As long as states are doing something, which by now almost all of them are, it is extremely difficult to convince a judge that it is not sufficient. Second, once states are doing something, questions of fact are complicated and time-consuming for attorneys to investigate. To discover whether the state has made treatment services adequately available, for example, can require: an extensive inventory of providers (including where they are located, what kinds of conditions they are capable of treating, whether they accept Medicaid patients, whether they are able to take new patients, etc.); testimony from parents about their experience in getting care for their children; and analysis of case histories and patient data. Not only is this discovery process extremely time-consuming, it also depends on skills most attorneys do not have: expertise related to how health care should be delivered and how to analyze data on EPSDT programs. Third, judges are reluctant to involve the courts in the administration of programs, believing that to be an inappropriate role.

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[31] The plaintiffs have requested that the opinion be reconsidered.

In some situations, litigation can still be a useful tool for enforcement. With carefully selected issues, it will be possible to demonstrate that a particular aspect of an EPSDT program fails to comply with federal law. Those aspects of programs which tend to be the least well developed--such as dental care, follow-up and treatment--are the areas where litigation can probably be most constructive. But unless there are significant changes clarifying EPSDT law and setting program standards, litigation will have limited impact in prodding states to establish quality programs. Nor should taxpayers have to seek remedy in the courts as the last resort for getting EPSDT implemented and needy children served.

Recommendations

1. Despite the problems of administering EPSDT through Medicaid, transfer of administrative responsibility should not be made because it would disrupt and slow implementation of the program. This is unjustifiable when other agencies have not had better track records for implementing and enforcing child health programs and when the overriding reason for EPSDT reform is to increase the benefits to children immediately.

2. Title XIX should be amended to require that Medicaid state plans address how EPSDT provisions will be carried out (including at least those provisions listed in Recommendation #3 below) and to require that the planning process include significant public involvement. States must hold public hearings on the plan and make revisions annually, based on information gathered at public hearings and on results from sample surveys ascertaining how widely services are known and available.

3. HEW should immediately consolidate the original EPSDT regulations with the subsequent penalty regulations to produce one clearly defined, internally consistent set of rules and regulations. Federal regulations should establish standards designed to

measure what services children actually receive. These should include:

- a. a standard for outreach and assessment, measured by comparing the number of children who receive assessments to the number who should have received them; and
- b. a standard for diagnosis and treatment, measured by the number of children who receive follow-up care compared to the number of children with problems identified by an assessment.

In addition, states must assure that specific standards of adequacy related to administration and quality of care are met. States should be required to:

- a. inform all families with eligible children about their rights under EPSDT, including the right to:
  - 1) receive a complete health assessment promptly following a request, at such times as are appropriate to the child's age and needs, from a qualified Medicaid provider, freely chosen;
  - 2) receive prompt diagnosis and treatment for health problems found;
  - 3) receive transportation assistance if needed; and
  - 4) receive a fair hearing if the family believes that rights under EPSDT have been denied;[32]
- b. assure that EPSDT is offered as a voluntary service;
- c. assure that there are adequate mechanisms to set up appointments and to provide transportation for children to get to assessments and treatment;
- d. establish a mechanism to ensure that children assessed through the program have received the full range of needed assessment procedures;
- e. assure that the full range of needed health services are provided subsequent to an assessment;
- f. demonstrate a working case management or follow-up system, including:
  - 1) clear assignment of responsibility for follow-up;
  - 2) adequate staff capacity in the responsible agency; and
  - 3) a record keeping system that allows prompt identification of children who have not received needed care;

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[32] Medicaid law requires that the state agency grant an opportunity for a fair hearing to any person "whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." (42 U.S.C. §1396a(a)(3).)

g. identify all qualified providers of assessment and follow-up care, and take measures to encourage their participation in EPSDT, including setting reasonable rates and terms for reimbursement for their services; and

h. submit to HEW as part of its Medicaid plan a complete explanation of how EPSDT requirements will be carried out. The plan must be revised annually following public participation.

4. HEW should issue guidelines indicating those aspects of EPSDT programs for which states are encouraged to establish a program development plan.[33] The guidelines should identify important program features which have been most difficult to implement properly, and should urge states to plan steps to be taken during the year to address these problems. These should include, for example, how the states plan to:

a. reach the unreached or hardest to reach eligible population;

b. develop needed resources for general medical and specialist care;

c. encourage the provision of EPSDT through comprehensive care providers; and

d. address the problems encountered in providing services to meet the developmental needs of children.

5. Considerable technical assistance should be made available to states to improve EPSDT programs. HEW must increase immediately its capacity to provide technical assistance.

6. States and localities should receive financial assistance to improve the administration and program performance of EPSDT. Title XIX should be amended to increase the federal match to states for EPSDT administrative services, community-based outreach services, and assessments and outpatient care following assessments, to a national average of 90 percent (the exact rates of federal reimbursement among the states would vary as they do now for medical services under Medicaid). To assure that increased federal assistance leads to a strengthened EPSDT program, states must be required to maintain their current level of financial commitment in the program.

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[33] Unlike the EPSDT part of the *Medicaid state plan* which is a legal document and which demonstrates that the state is carrying out its legal obligations under EPSDT, the *program development plan* is a tool for improving the program. It sets out how the state intends to deal with certain program issues for which there are no legal requirements, but for which there must be an effective strategy if EPSDT is to work well for eligible children.

7. HEW should monitor progress of EPSDT in the states by requiring that states submit data according to revised federal reporting requirements (see recommendation 4 in Chapter 3, and recommendation 6 in Chapters 4 and 5 for more details of these reporting requirements). HEW should investigate the reasons for any significant departures from national norms in any state.

8. HEW should conduct reviews of state compliance with EPSDT requirements on a quarterly basis for states found out of compliance during the past quarter and semi-annually for all other states. Reviews should consist of evaluating state Medicaid plans, EPSDT program development plans, and audits of individual case records to assure that requirements for timely assessment and treatment are met and that data reported by the state is accurate. Site visits should be made to randomly selected counties (the number to be in proportion to the number of counties in a state) to monitor whether state obligations are carried out properly.

9. HEW must use enforcement tools capable of assuring that EPSDT reaches its intended beneficiaries. HEW should conduct regular reviews of state compliance with EPSDT requirements by evaluating the adequacy of state plan material related to EPSDT and by making site visits to randomly selected counties in each state. As a supplement to the Secretary's authority to cut off a state's Medicaid funds, Title XIX should be amended to require the Secretary to use one of two remedies when, following the opportunity for an administrative hearing, violations in a state's EPSDT program are found. He should have the authority to withhold 20 percent of the federal share of the state's administrative costs for the Medicaid program; alternatively, he should have the authority to issue an order for the state to provide the requisite services. In the latter instance, the state should have a 30-day period during which to appeal the finding of noncompliance to a United States Court of Appeals. If the state does not appeal within 30 days or if the Court does not disagree with the Secretary's decision, then the order is enforceable through the courts, either by the Secretary or by a program recipient. Strict timetables which guarantee that compliance reviews, citations for noncompliance, administrative hearings and consideration of appeals are carried out expeditiously must be established. These provisions should in no way interfere with the right of recipients to initiate private litigation to enforce their rights under the EPSDT program.

10. At the state and county levels, one person should be designated responsible for EPSDT. In addition, each state and county administrator should seek a pediatric and a dental advisor whose job it is to encourage cooperation and support of providers and to lend technical expertise to the program administrator.

11. Parents and advocates must help plan and improve the EPSDT program and actively monitor the adequacy of the program to assure that federal requirements are carried out and that children receive the services to which they are entitled. To determine the adequacy of the program, they should:

a. ask for available EPSDT statistics and compare progress in the community to federal standards for assessing and treating children;
b. determine whether arrangements for setting up appointments, providing transportation and other support services are adequate;
c. monitor the thoroughness of assessments performed, by analyzing data collected by the state to determine whether children are receiving the full set of needed procedures;
d. evaluate the appropriateness of state standards and the process for certifying providers as well as the extent to which qualified providers are encouraged to participate in the program;
e. inventory whether there are enough resources for assessments, diagnosis, and follow-up care so that children get needed services promptly;
f. make known through public education efforts that they would like to meet with parents of Medicaid eligible children to learn of their experiences with EPSDT; and
g. review sample surveys conducted by the state to determine the extent to which families with Medicaid children know about and have received EPSDT services.

Once areas needing improvement are identified, parents and advocates should bring to bear a variety of tools including:

a. participation in public hearings around establishing the EPSDT portion of the Medicaid plan;
b. negotiations with state and local Medicaid administrators;
c. meetings with staff in HEW regional and central offices;

d. individual or group Medicaid fair hearings;
e. hearings before the state legislature;
f. written complaints to key government officials and to members of Congress;
g. public disclosure, including local news coverage; and
h. lawsuits to compel that services be provided to a class of children.

Chapter 3

Is EPSDT Reaching Needy Children?

One of the first things we wanted to know about EPSDT was whether it was carrying out its most basic charge--that of reaching the children it was intended to serve. Were needy children whose families could not afford health care receiving preventive and primary care through EPSDT? The answer to this question involved two steps. The first was determining whether, with its eligibility criteria, EPSDT *could* reach needy children. The second was looking at whether the *outreach* (i.e., finding eligible families, informing them about the program and urging them to use its services) was being done effectively.

What the Data Show

Many Needy Children Are Not Eligible

As we explained earlier, only children who are eligible (and certified) for Medicaid can receive EPSDT services. Because of the specific requirements states have adopted to determine which children qualify for Medicaid, many needy children are not eligible. In 1974, there were 23.8 million children under 21 living in families with incomes below $7,500--enough to pay for food, clothing and housing but not enough for any major medical expenses.[1] Yet during the course of the year, only about 13 million children were certified for Medi-

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[1] U. S. Bureau of the Census, *Current Population Reports*, P-60, No. 102, "Characteristics of the Population Below the Poverty Level: 1974," Table 45, p. 128. Estimates of how many persons aged 18 to 21 lived below 150 percent of the poverty level were made by using the general age composition of the poverty population. An undeterminable number of persons in this age group included mothers and fathers of still younger children.

In 1974 (the most recent year for which such analyses have been made), an income below $7,500 for a family of four (or about 150 percent of the national level used to define poverty) met only a family's minimum needs for food, clothing and housing. This income level of $7,500 permitted no major medical expenses, no savings and no child care expenses. (*America's Children 1976: A Bicentennial Assessment* (Washington, D.C.: National Council of Organizacaid[2] and only about 10 million were on Medicaid at any one point in time.[3]

The reasons for this disparity between the number of children who need services and the number who meet eligibility requirements are several. First, federal law allows states to establish policies that base eligibility on factors unrelated to income. Many have done so, with the result that children in families too poor to pay for health care still cannot qualify for Medicaid. More specifically, 21 states or territories did not permit "medically needy" families to qualify for Medicaid; 22 states or territories did not cover poor children in families with unemployed fathers; and 37 states or territories did not cover *all* children who met income but not "categorical" requirements.[4]

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tions for Children and Youth, 1976), p. 16.) For a more thorough discussion of poverty levels and their rationales, see *The Measure of Poverty*, a report to Congress as mandated by the Education Amendments of 1974 (Washington, D.C.: HEW, April 1976).

[2] This assumes a turnover rate of 30 percent among Medicaid-eligible children. No unduplicated counts of children eligible throughout a year are reported to SRS by the states.

[3] At the end of fiscal 1975 there were 9,983,000 children eligible for EPSDT. At the end of fiscal 1976 there were 10,280,000 children eligible. States varied in the methods by which they calculated or estimated the number of children eligible for Medicaid services. Some states (New York, for example) drew the figures from local records of the Medicaid program; others (Michigan, for example) used demographic projections. The state-by-state figures for eligible children are in Appendix F, Table 3.

[4] See Table 1 in the Introduction to this report for a list of states' eligibility requirements. Under 42 U.S.C. §1396d(a)(i) of the Medicaid law (one of the so-called Ribicoff Amendments), states are given the option of covering individuals under the age of 21 who are "financially eligible." That is, eligibility may be extended to children who do not qualify as dependent children under a state's AFDC plan, but whose families meet the state-defined income standards for assistance. The implementing regulation (45 C.F.R. §248.1(c)(iv)) allows states to limit such optional coverage to "groups of such individuals if based on reasonable classifications." Such *subgroups* may be composed, for example, of children under 21 in foster homes, psychiatric hospitals or intermediate care facilities, or of children in subsidized adoption for whom public agencies are assuming at least partial financial responsibility.

Recently, HEW sought an opinion from its General Counsel as to the legality of this regulation. The General Counsel ruled that the regulation was not supported by law and concluded that coverage must be on an "all or nothing" basis. That is, if the state wishes to cover any children in the optional group, it must cover all such children. As a result, word was sent to all Regional Commissioners administering Medicaid that no further state plan amendments proposing coverage of subgroups of children could be approved.

The Children's Defense Fund has reached a different conclusion, however, regarding eligibility for subgroups. The present regulation was originally promulgated in reliance upon 42 U.S.C. 1396d(a)(i), which provided that states were required to make efforts in the direction of:

> broadening the scope of care and services made available...and liberalizing the eligibility requirements...with a view toward furnishing by July 1, 1977 comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources....

Thus, a large number of children who were not on welfare but who lived in poverty were not eligible for Medicaid or EPSDT services.

Second, states have established income levels for Medicaid eligibility that are extremely low and that exclude many families too poor to pay for health care. Financial eligibility levels varied greatly among states, but the highest was $4,800 for a family of four, and only eight states (Alaska, Hawaii, Iowa, Michigan, New York, Ohio, Vermont and Wisconsin) used cutoffs higher than $4,500.[5] Three states (Louisiana, North Carolina and Texas) used cutoffs lower than $2,500. The income levels for Medicaid eligibility in CDF's study states are shown in Table 1. (When looking at them, bear in mind that families with incomes of $7,500 cannot afford most medical care.)

These categorical and financial eligibility restrictions meant that, during a year, only 13 million of 23.8 million, or 56.4 percent of needy children, were eligible for EPSDT services.

Many Eligible Children Are Not Reached

Leaving aside the issue of eligibility, there remains the question of the extent to which those children who *were* eligible were reached by EPSDT. To answer this we should have compared how many children were screened to how many were eligible. Unfortunately, the way EPSDT data were reported to HEW did not permit us to do this, since the number of *screenings* performed and not the number of *children* screened each month was reported. In 1975, over 1.4 million screenings were performed, or about 15 screenings per 100 eligible children. In 1976, 1.7 million screenings were reported performed which added up to about 17.2 screenings per 100 eligible children

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This section was repealed in 1972. The legislative history surrounding the repeal of 42 U.S.C. §1396d(a)(i) indicates that Congress' intent was *not to force states into immediate comprehensive coverage* by eliminating the grace period until 1977, but to *remove the requirement of comprehensive coverage.* The Senate Finance Committee reported.

> The committee has been concerned with the burden of the Medicaid program on State finances. The expansion of the Medicaid program and liberalization of eligibility requirements for medical assistance which is required by §1396d (a)(i) could increase this burden and may result in States either cutting back on other programs or their considering dropping Medicaid. (Senate Report No. 92-1230, pp. 201-202.)

Similar language can be found in the report of the House Ways and Means Committee. (House Report No. 92-231.) Since authorization for the "reasonable classification" regulation was initially found in 42 U.S.C. §1396d(a)(i)'s provision for gradually expanding eligibility, it is anomalous to conclude that the repeal of §1396d(a)(i) undermines the authority for the regulation when the reason for repeal was that the section forced states to expand services too quickly.

[5] Committee on Interstate and Foreign Commerce, U. S. House of Representatives, *Data on the Medicaid Program: Eligibility, Services, Expenditures Fiscal Years 1966-76* (Washington, D.C.: U. S. Government Printing Office, 1976), pp. 63-65.

Table 1

MAXIMUM INCOME LEVELS FOR MEDICAID ELIGIBILITY FOR A FAMILY OF FOUR IN CDF STUDY STATES

State	Medicaid[1]	Medically Needy[2]
Michigan	$4,800	$4,900
Mississippi	3,324	n.c.[3]
New Jersey	4,272	n.c.
New York	4,704	5,000
South Carolina	2,604	n.c.

[1] As of July 1974, these were the maximum income levels to qualify for most categories of Medicaid eligibility.

[2] As of December 1974.

[3] n.c. = not covered.

Source: Committee on Interstate and Foreign Commerce, U. S. House of Representatives, *Data on the Medicaid Program: Eligibility, Services, Expenditures Fiscal Years 1966-76* (Washington, D.C.: U. S. Government Printing Office, January 1976), pp. 63-65.

Not all eligible children need to be screened each year. Some age groups need to be screened only every two or three years. Therefore, to get a more accurate view of how effectively EPSDT was reaching eligible children according to their need, we compared how many screenings were reported to how many *should* have been done--according to both the schedule for screenings, recommended by the American Academy of Pediatrics (AAP) and to the states' own screening schedules.[6]

Using the AAP's schedule as a national standard, in 1975, EPSDT performed about 22.5 percent of screenings needed by eligible children. In 1976, the program performed about 25.8 percent.[7] Thus, EPSDT programs across the country were performing about a quarter of the screenings needed by eligible children.

In our study states, there was wide variation in how effectively programs were reaching eligible children. Table 2 shows their screening rates for fiscal 1975, the year we made most of our site visits. New Jersey failed to carry out almost 19 out of every 20 screenings that would be required to meet the AAP's standard, while South Carolina carried out 2 of every 5 screenings needed to meet that standard.

[6] Because no data were available on the extent to which Medicaid children received needed screens through sources other than the EPSDT program, we were unable to account for such children in our estimates. Similarly, we have counted as screenings any screen reported by a state, even though it was not possible to determine whether the screen included the full set of procedures set out in EPSDT guidelines. See Appendix H for calculations on how many children states *should* be screening.

[7] These percentages are derived from 1975's 15.0 screenings per 100 eligible children divided by the AAP's standard of 66.7 screenings per 100 eligible children; and 1976's 17.2 screenings per 100 eligible children divided by 66.7 per 100 eligible.

Table 2

SCREENINGS PERFORMED IN FISCAL 1975 IN CDF STUDY STATES COMPARED TO STANDARDS SET BY THE AMERICAN ACADEMY OF PEDIATRICS

State	Eligible End of Year	Screenings During 1975	Screenings per 100 Eligibles	Percent of Screenings Performed Compared to AAP Standard[1]
National Totals	9,982,999	1,474,015	15.0	22.5
Michigan	530,004	124,270	23.4	35.1
Rank in nation[2]	(5)	(2)	(21)	(21)
Mississippi	151,563	36,818	24.3	36.5
Rank in nation[2]	(19)	(9)	(19)	(19)
New Jersey	376,544	14,211	3.8	5.7
Rank in nation[2]	(8)	(29)	(50)	(50)
New York	1,169,119	126,856	10.9	16.4
Rank in nation[2]	(2)	(1)	(37)	(37)
South Carolina	110,483	30,138	27.3	41.0
Rank in nation[2]	(24)	(19)	(16)	(16)

[1] This rate is derived from the ratio of screenings performed by states per 100 eligible children compared to the AAP's standard of 66.7 screenings per 100 children. For a derivation of the standard, see Appendix H.

[2] Ranking of 1 is assigned to the state with the largest numbers (either of eligible children, number of screenings or best performance) among all the 51 states and territories that reported both counts of eligibles and of screenings.

Source: "National EPSDT Statistics for Fiscal Year 1975." (See Appendix F) Calculations by CDF.

When the screening rates in the states were compared to their own screening schedules (which like most features of the EPSDT program were left to the states' discretion), they still did not reach the minimum levels required to screen all the children eligible for the program. Table 3 shows the states' effectiveness when compared to their own screening standards. Mississippi and New Jersey planned the most frequent screenings for eligible children (one screening per child per year), and so their record appeared worse than when they were compared to the less frequent AAP standard. On the other hand, Michigan and South Carolina planned to screen less often than the schedule recommended by the AAP, and they did not meet even their own standards. New York was the only state which used the AAP's standard, but it fell short of reaching it.

When we looked at the screening rates in our five counties, only one met its state's screening standard. As Table 4 shows, Florence County met the South Carolina screening standard, although it did not reach screening levels that would have satisfied the AAP's standard. For the other four counties, the screening performances were dismal. Essex County, with the poorest performance, performed only 1 out of every 25 screenings required by the state.[8]

Table 3

SCREENINGS PERFORMED IN FISCAL 1975 IN CDF STUDY STATES COMPARED TO STANDARDS SET BY EACH STATE

	Screenings Per 100 Eligibles	Screenings/ 100 Eligibles: State's Own Standard	Percent of Screenings Performed Compared to State's Standard
Michigan	23.4	42.9	54.5
Mississippi	24.3	100.0	24.3
New Jersey	3.8	100.0	3.8
New York	10.9	66.7	16.4
South Carolina	27.3	42.9	63.6

Source: "National EPSDT Statistics for Fiscal Year 1975." (See Appendix F.) Calculations by CDF.

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[8] The fact that all five of our study counties equalled or surpassed the overall performances for their respective states was probably not accidental, since we chose programs that were reported to have been functioning well for a period of time.

Table 4

SCREENINGS PERFORMED IN CDF STUDY COUNTIES DURING 1975-76[1] COMPARED TO STANDARDS SET BY EACH STATE AND BY THE AMERICAN ACADEMY OF PEDIATRICS

County	Eligible End of Year[2]	Screenings During Year[2]	Screenings Per 100 Eligibles	Percent of Screenings Compared to State's Standard	Percent of Screenings Compared to AAP Standard[3]
Genesee County, Michigan	32,204	8,466	26.3	61.3	39.5
Oktibbeha County, Mississippi	3,000	1,014	33.8	33.8	50.7
Essex County, New Jersey	144,000	5,537	3.8	3.8	5.8
Suffolk County, New York	37,935	6,111	16.1	24.2	24.2
Florence County, South Carolina	3,501	1,550	44.3	103.3	66.4

[1] In each case, the data cover a one year period but the dates differ for our study counties, ranging from fiscal year 1975 to fiscal year 1976 (and including some calendar year data within that period). Similarly the sources of the data range from rough estimates by local EPSDT officials to well-documented reports. Appendix J discusses the data from which this table was constructed.

[2] The figures for eligibles and for screenings required approximations in several cases and should not be taken as exact numbers.

[3] For a derivation of the standard, see Appendix H. The effectiveness ratio is the percent of the standard attained by each area.

Source: Appendix J.

The effect of the nearly *universal* failure to meet screening targets was stark. Many children were not screened at all. Other children were screened less often than the periodic schedule required. Not only were too few eligible children of any age reached by EPSDT, but children under age 3 and over age 16 were badly underserved.[9] Nationally, there were about 5.2 million too few screenings in fiscal 1975 and about 5.1 million too few in fiscal 1976. In our five study states, there were over 1.2 million too few screenings in fiscal 1975, most of which were attributable to New York because of its size and New Jersey because of its abysmal screening performance.

Effective Outreach Methods Are Not Used

Why were eligible children not being reached by EPSDT? Among several key reasons, perhaps the most important was that the kind of measures that effectively reach out to families and attract them to the program generally were not used. It has always been difficult to get families to use preventive health care, yet prevention is what EPSDT is all about. The relationship between a raging fever and a doctor is straightforward and immediate. But families need considerable information to become interested in the longer-term benefits of early screening and prevention. And especially for the poor, the practice of early, routine care never became a health habit. In many places, prior to EPSDT, except for immunizations and checkups for infants, preventive health care was unavailable for those who could not pay.

Thus, one study of low-income families found that 53 percent of the respondents agreed that "there is no need to see a doctor regularly if you are not sick," and that 25 percent believed that "doctors only want to see you if you are sick--they don't want you to come in just for a checkup." Both percentages dropped after a health center began a program to educate residents about the value of preventive health care.[10]

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[9] See Appendix I for a more extensive discussion of the age composition of children screened.

[10] This same study found that only 17 percent of the respondents had received a general health examination during the previous 12 months. S. Belin and H. J. Geiger, "The Impact of a Neighborhood Health Center on Patients' Behavior and Attitudes Relating to Health Care: A Study of a Low-Income Housing Project," in Robert M. Hollister, Bernard M. Kramer and Seymour S. Belin (eds.), *Neighborhood Health Centers* (Lexington, Mass.: Lexington Books, 1974), p. 216. The National Health Survey found, in addition, that among families with incomes below $5,000, fewer than 10 percent of all physicians' visits are for preventive purposes such as general examinations and immunizations. Public Health Service, *Health Characteristics of Low-Income Persons* (Washington, D.C.: HEW, 1972), p. 8.

Recognizing that those eligible for EPSDT--poor children outside a system of preventive care--would be hard to reach, members of Congress stressed the need for vigorous outreach measures. They envisioned that

> organized and intensified case-finding procedures will be carried out in well-baby clinics, day care centers, nursery schools, Head Start centers in cooperation with the Office of Economic Opportunity, by periodic screening of children in schools, through follow-up visits by nurses to the homes of newborn infants, by checking birth certificates for the reporting of congenital malformation and by related activities.[11]

Building on this legislative history, HEW issued regulations and explicit policy guidelines for how states should inform eligible families about the EPSDT services.[12] HEW advised that,

> to actively seek out eligible individuals for the EPSDT program, the State agency should develop procedures: (a) to inform parents that these services are available for their children, and when and where they are provided; (b) to make sure that they understand the nature and purpose of the screening program; (c) to enlist the help of other community agencies in case-finding activities; and (d) to assure that families are helped, if they need such assistance, to obtain transportation to the screening center and for diagnostic studies and treatment.[13]

In 1972 Congress emphasized again the importance of outreach in implementing EPSDT when it wrote into law states' obligation to

> inform all families in the State receiving aid to families with dependent children...of the availability of child health screening services under the plan of such State approved under Title XIX.[14]

To underscore the seriousness of this mandate, failure to inform eligible families was one of the few specific requirements of EPSDT that triggered a financial penalty.[15] Regulations defined "informing" as notifying AFDC families at least once a year in writing of what EPSDT services were available and how and where to obtain them.[16]

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[11] U. S. House of Representatives, Report No. 544, 90th Congress, 1st Session 127 (1967); see also U. S. Senate Report No. 744, 90th Congress, 1st Session 194 (1967).

[12] Regulations issued by HEW required state Medicaid agencies (1) to identify eligible persons, including those who need services furnished by Maternal and Child Health and Crippled Children's programs funded under Title V of the Social Security Act; (2) to assure that they are informed of services; and (3) to assure that they are referred to Title V grantees for care. (45 C.F.R. §249.10(a)(3)(ii).)

[13] *Medical Assistance Manual*, Part 5, 5-70-20(D)(1). See also, *Medical Assistance Manual*, Part 5, 5-70-20(C) and (D) for HEW's guidelines further defining EPSDT eligibility and case-finding.

[14] 42 U.S.C. §603(g)(1).

[15] 42 U.S.C. §603(g). See Chapter 2 for more information about the provisions of the EPSDT penalty statute enacted in 1972.

[16] 45 C.F.R. §205.146(c)(i).

While Congress's aim was worthy, there were two serious flaws in the new language on outreach, and these were compounded by states' misinterpretation of their responsibility under the law. First, written notices alone are not effective forms of outreach. Second, the requirement that only AFDC recipients be notified meant that other categories of children eligible for Medicaid might not be informed.[17] Although, as we explained in Chapter 2, the requirements in the EPSDT penalty statute were meant to supplement and not substitute for other EPSDT requirements, we found that in most states the kind of outreach performed was closer to the narrower definition in the penalty requirements than to one defined in regulations and guidelines.

Written Notices

EPSDT programs in each of our study sites complied with the written notice requirement by enclosing with AFDC checks a brochure explaining EPSDT. (Michigan and New York went beyond the requirement by sending notices to families of *all* children certified for Medicaid.) Everywhere we went, program administrators and recipients alike acknowledged that written notices had little impact. Written material about EPSDT was seldom read and even less often understood or heeded. We were told that, often ignored as "junk mail," written notices did not get the message across.

"Many mothers can't even read the flyer they sent out," said a Genesee County Head Start worker.

"The literature we get," a Suffolk County welfare mother told us, "doesn't lend itself to reading...That stuff just gets tossed away. And it should."

No parent we talked to had been motivated to have her or his child enter the EPSDT program because of a written notice. "They hand you so many forms and send you so much literature you just don't bother to delve in and see what it's about," said a welfare mother in Suffolk County.

There is nationwide evidence confirming that written notices alone are not effective forms of outreach. For example, a study of different case-finding methods in Contra Costa, California found that

> letters and telephone calls as case-finding methods have limited success in generating participation in an EPSDT program--

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[17] The reason for requiring that only AFDC children be notified was the alleged difficulty of monitoring outreach to children other than those on welfare. (Senate Report 92-1230, Report of the Committee on Finance to Accompany H.R. 1, the Social Security Amendments of 1972, p. 299).

resulting in less than five percent of the target population screened.[18]

Outreach at the Welfare Office

Because all AFDC recipients must come to the welfare office for certification, and because they constitute the bulk of Medicaid recipients, it seemed logical to do outreach for EPSDT through the welfare office. Nearly every state in the country conducted at least part of its EPSDT outreach there.

Brochures describing EPSDT, developed by each of our study states, were generally available at local welfare offices (except in Mississippi, where staff at the local welfare office we visited were unaware of any written materials about EPSDT). Families received EPSDT brochures when they came to the welfare department for initial certification or recertification for welfare and/or Medicaid benefits.

In addition to brochures, some of the welfare agencies had other outreach services:

- In Suffolk County, when the worker handling the financial aspect of recertification determined that a child had not received EPSDT services, the parent was sent to another office to discuss the EPSDT program with community aides.
- In Essex County, the caseworkers visited the home and asked a series of questions about the health services children in their caseload received. If they seemed to need screening, the workers explained that they could go to a health provider.
- In Genesee County, the visiting caseworker not only referred the family to the screening provider but made appointments and other arrangements on the spot if necessary.
- The procedure was similar in Florence County, but there EPSDT was the clear, central focus of the home visit.

What seemed logical on an organizational chart, however, did not always work in reality. Even though all AFDC recipients passed through the welfare office, outreach there was generally not effective. Unless specially trained, welfare intake workers generally did not know enough about EPSDT or children's health issues to provide adequate explanation to parents. Furthermore, outreach was carried out by the same agency, and sometimes by the same individual, upon whom the client was dependent for financial survival. In the midst of the anxiety and other emotions involved with being certified for welfare, the message about EPSDT services was likely to be garbled, ignored or misunderstood. As one welfare mother in New York said:

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[18] Harry W. Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, January 1976), p. v; and *Doctors and Dollars Are Not Enough* (Washington, D.C.: Children's Defense Fund, 1976), pp. 27-31.

> Anyway, people aren't in the mood to hear about it after they go through recertification. They have just one thing on their minds: Can they keep getting the benefits they must have? Keep your eyes open and ears open and you will throw-up when you come out. It's such a hassle and such an uncomfortable time. Telling people about [EPSDT] at a recertification visit is crazy.

And another added,

> Parents see [the program] as just another form to fill out, just another concern with numbers, and say: "I dont' want my child to be another number." Parents feel you are getting into their personal, financial lives and would rather you didn't ...as you speak with them you can feel this hostility.

Ambivalence, misunderstanding and misinformation resulted when EPSDT outreach efforts were conducted by welfare caseworkers. As a Community Action Agency staff member in Flint, Michigan, put it:

> Because welfare has a particular attitude toward poor people, lots of families I work with don't use the services. Welfare workers don't feel people's problems. They do it because it's their job and welfare recipients know that. Every encounter with caseworkers like that reminds them they are on public assistance. But mothers have had it with the special bitterness. They're too proud to do what the caseworkers say.

We found some instances where language bordering on threats was used to convince mothers to use EPSDT screening services. We also found places where workers indirectly coerced mothers to take their children for screening by implying that if they did not, their family might lose eligibility for welfare. One welfare recipient referred to EPSDT as "the compulsory annual exam program."

Staff at an Essex County community service agency reported instances where families believed that their welfare checks would be cut off if their children were not screened. The same was true in Suffolk County, where staff at a health center reported receiving a number of calls from clients who feared they would not be recertified for welfare if their children were not screened.

A Florence County caseworker told us that when she informed families about screening, she did not "give them an option." Another caseworker told mothers who were reluctant to participate that the "state will be told about their refusal of screening."

Outreach By Community Organizations

The solution to many of the limitations of outreach conducted by the welfare department is simply for states to arrange for outreach to be done by people and organizations not associated with the welfare system, people who have or can develop the necessary rapport with poor families, and who have the knowledge about child health to inform families of the importance of preventive care provided through EPSDT.

The merits of community-based outreach are captured by a story told to us by an outreach worker in the Community Action Agency in Florence, South Carolina:

> One family I work with is real poor. They're too proud to apply for welfare or food stamps but they can't pay for much of anything the children need. I could tell that one of the kids had problems seeing. There are six others and one of those is "disturbed," I think, and surely should have some special help. Their house is so cold I sometimes have to make an excuse to go to my car for a few minutes to warm up. They will starve before they give themselves away if you don't know how to reach them, even if they are aching with problems. I have tried a few times to get them to take the two kids to the doctor. I know they've never been because the parents could never pay. One day I went in and took off my shoes and sat on the floor. I guess the mother saw me as much more on her level and poured out her story and we talked. Sure enough, they finally applied for welfare and got EPSDT. The boy's eyes were operated on and next week I'll be taking him to get the right glasses.

Nearly every report evaluating outreach to low-income persons has concluded that community residents play a vital role and that there should be formal mechanisms for their involvement.[19] Looking at the EPSDT program in Idaho, for example, the Office of the Comptroller General of the United States found that of various methods used, trained welfare mothers were most effective in educating families and in encouraging them to have their children screened.[20] In the few places where Medicaid recipients and community organizations have been actively involved in EPSDT outreach, the results have been striking. In Las Vegas, Nevada, for example, a community health center called Operation Life, Inc. relied on trained welfare mothers to do outreach for EPSDT. The center screens the vast majority of children screened in Nevada, and community involvement was a major reason why Nevada was among the leaders in the nation in reaching eligible children.[21]

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[19] For a summary of some of these studies, see *Doctors and Dollars Are Not Enough*, pp. 27-31.

[20] Of the four regions evaluated, the one using primarily written notices for outreach attracted 3 percent of families contacted to the EPSDT program. The three other regions that engaged in extensive "personal" outreach had participation rates ranging from 16 to 35 percent. The authors reported that "the region with the 35 percent screening rates used personal service aides--mothers who had been receiving assistance under the AFDC program --to help provide outreach services to eligible families." (Comptroller General of the United States, *Improvements Needed to Speed Implementation of Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program* (Washington, D.C.: Social and Rehabilitation Service, HEW, January 9, 1975), p. 15.)

There is a strong basis in the Medicaid statute for having community people perform EPSDT outreach. It mandates the training and hiring of paraprofessionals, with particular emphasis on the employment of Medicaid recipients and other persons of low income.[22] Yet, despite this and the federal guidelines recommending the use of community agencies in EPSDT case-finding,[23] we found that in most places these organizations were not used at all to spread the word about EPSDT. Where they were used, their role was limited by a lack of financial support or lack of cooperation from the local welfare and health agencies.

The most serious policy barrier to using community organizations for EPSDT outreach is a Medicaid policy requiring that in order to be reimbursed by the federal government at the attractive level of 75 percent, outreach must be carried out by employees of "an identifiable Medicaid or EPSDT unit at the local level," and under the direct supervision of "skilled professional medical personnel."[24] These provisions precluded funding community-based organizations and made it difficult even for smaller welfare departments, not large enough to employ a medical professional or to establish a separate Medicaid unit, to qualify for outreach reimbursement.

In our study sites, we found no organization other than the welfare department reimbursed by Medicaid for EPSDT outreach. Community organizations, such as Head Start centers and community health clinics, providing health services for children were unable to obtain reimbursement for EPSDT outreach from the state Medicaid agency.

The situation in Newark, New Jersey was typical. A neighborhood health center and a community-based, preventive health care clinic in Newark had been certified to receive reimbursement for EPSDT screening. Both employed outreach workers from the community who visited residents, informing them about health care and available EPSDT services. Yet both of these organizations were denied Medicaid reimbursement to cover the costs of these outreach efforts. Their resources were so strained that they could not devote significant staff time to outreach for EPSDT services without curtailing other important activities.

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[21] Jack Anderson, "The EPSDT Program: An Opening in the Health Industry for CDCs and Other Community Organizations?" (Berkeley, Calif.: *Economic Development Law Project Report*, Vol. 7 (January-February 1977), pp. 14-17.

[22] 42 U.S.C. §1396a(a)(4)(B).

[23] *Medical Assistance Manual*, Part 5, 5-70-20(D)(1)(c).

[24] *Medical Assistance Manual*, 2-41-20(C)(7). See also 42 U.S.C. §1396b(a)(2), and 45 C.F.R. §250.120(a).

We found, too, that federal directives designed to protect the confidentiality of children on welfare[25] have been interpreted by welfare departments so that they did not give community organizations doing outreach the names of children eligible for Medicaid. Officials in Michigan told us, for example, that a state law conforming to federal law did not allow lists of eligible children to be given to certain organizations in order for them to do outreach and screening. In Oktibbeha County, Mississippi, the director of Head Start, who wanted to make sure children in her program had been screened, reported she was unable to get the names of Head Start children on Medicaid from the welfare department.

These federal directives and state laws were intended to protect Medicaid children from being singled out in settings where they were with non-Medicaid children, violating their privacy and inviting discrimination. Community organizations representing poor people, however, are best suited to explaining programs designed to serve their clients and are likely to be sensitive and not discriminatory to EPSDT children.

Outreach by Organizations Serving Children

We found generally that other organizations that have regular contact with children--child care centers, Head Start centers and schools--were not used to reach out to children for EPSDT services. These institutions can provide an important resource for EPSDT by locating children who need services, referring them to the program, helping set up a screening appointment, transporting children, and checking to assure that needed care following screening is received. Recognizing the potential benefits of such cooperation, in 1974 HEW's Office of Child Development set up an EPSDT demonstration program. Two hundred Head Start centers across the country received small grants for a two-year period to assist Head Start children and their siblings to get EPSDT screening and treatment. However, with the exception of this demonstration, neither federal, state nor local officials have made a sufficient commitment (by providing funds or technical assistance) to using these and other organizations to help reach needy children. Thus, an in-depth analysis of the EPSDT experience of 30 Head Start centers concluded:

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[25] See 42 U.S.C. §602(a)(9), 42 U.S.C. §1396 a(a)(7), and 45 C.F.R. §205.20 as amended by 40 C.F.R. §52375-6, November 10, 1975 and two HEW policy statements which interpret them. See *Medical Assistance Manual*, Part 5, 5-70-20(E)(5) and 5-70-9.00, Question 17.

> There was minimal provision of assistance or support to Head Start projects by public agencies at any level...Many projects reported resistance by public agencies, particularly at the local level, regarding Head Start roles in the delivery of EPSDT services ...The paucity of formalized relationships tends to frustrate the efforts of community agencies such as Head Start to gain access to and recognition by this system.[26]

Other child care centers we visited were generally smaller than Head Start programs and provided few health services. We found no working relationships with EPSDT. Indeed, directors of child care programs in two study sites had never even heard of it. According to a recent state policy in Michigan, an EPSDT screen can fulfill the physical examination requirement for a child to enter Title XX-funded day care programs. Not only did the director of such a program not know about the policy, but she knew nothing about EPSDT.

School personnel had contact with children and parents--at registration, PTA meetings, or if vision and hearing testing or individual counseling was done--and could have used the opportunity to discuss the benefits of EPSDT and explain how to get services. However, health staff in schools generally did not refer children to EPSDT services.

Only in Genesee County did we see arrangements with schools which, although not geared specifically to EPSDT outreach, could perform that function. There the Health Department, the Board of Education in Flint and the Mott Health Center (which treats health problems in children which require specialist care) organized an Interagency Health Council to facilitate serving children in the Flint area. The schools employed home-school counselors who were community residents paid to act as liaisons between parents and schools. These counselors helped get needed health care for children, particularly follow-up for vision, hearing, dental and other problems detected at school.

Helping Families Establish Medicaid Eligibility

Even if states effectively reached children already certified for Medicaid, there would still be a problem in reaching children whose families could qualify but did not know they were eligible for Medicaid and therefore for EPSDT benefits. A Head Start health aide in Oktibbeha County told us:

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[26] *Revised Interim Report on Evaluation of Head Start/EPSDT Collaborative Effort* (New York: Boone, Young & Associates, Inc., October 20, 1975), p. v-25. For further discussion of problems encountered in the EPSDT Head Start collaboration and the lessons from it, see Community Health Foundation, *Head Start and Early and Periodic Screening, Diagnosis and Treatment: Recipies for Success* (Washington, D.C.: Office of Child Development, HEW Publication No. (OHD) 76-31097, August 20, 1976); and *Final Report: Head Start/EPSDT Collaboration Evaluation* (New York: Boone, Young & Associates, Inc., March 31, 1976).

> In one day care center in a neighboring county, there are only three kids on Medicaid although the county is one of the poorest in Mississippi. In this county, 60 percent of the residents have incomes below the poverty line but only 40 percent of those people have Medicaid cards. There is a dire need for more public information about available programs and services. The traditional channels just don't reach the people.

There simply are no incentives for welfare agencies to reach all children who could qualify for services. Outreach itself costs money, and if more families are found eligible for welfare or Medicaid, or more want screening, this creates more stresses on already tight welfare budgets and already heavy caseloads for social workers. As a director of a state Medicaid program told us, "the welfare office has strong financial disincentives to bring families in for services."

Not surprisingly, we found little being done to identify children who could qualify for Medicaid but had not yet done so.[27] Referral relationships between local welfare offices and other community services agencies existed only infrequently in our study sites.

One Head Start program in Suffolk County referred families who met eligibility criteria to the welfare office to apply for Medicaid benefits. However, nowhere did we find organized welfare department efforts to inform community agencies about welfare or Medicaid benefits and services.

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[27] The problem is particularly acute for families not already on welfare but who could qualify for Medicaid. The number of Medicaid recipients not on welfare is disproportionately small. In our two study states which offered Medicaid benefits to children other than those on welfare, the disparity was particularly striking. About 70 percent of poor families in New York were not on welfare (e.g., received no welfare check). (Bureau of the Census, U.S. Department of Commerce, *General Social and Economic Characteristics: New York*, PC(1) - C34, May 1972, Table 69.) But in New York, the income level to qualify for Medicaid in the "medically needy" category was higher than the poverty level. Thus, one would have expected most children in these families to be eligible for Medicaid, and that "medically needy" would have constituted the greatest proportion of Medicaid children. Yet of children eligible for EPSDT as of November 1974, 71 percent were welfare/AFDC children. (U.S. Department of Health, Education and Welfare Region II, EPSDT Penalty Reporting Form for New York, November 15, 1974.)

A similar situation existed in Genesee County, Michigan. There, children who were eligible for Medicaid, but not for AFDC benefits, constituted just 13 percent of certified Medicaid eligibles. (Internal memorandum from Bill Keller to Tom Freebury, Supervisor, Policy Development, Bureau of Medical Assistance, Michigan Department of Social Services, 18 September 1975.) Yet, as in New York, over 70 percent of all Genesee County families with incomes below the poverty level (in most of which the children would have been eligible for Medicaid because Michigan covered all financially eligible children) did not receive cash assistance. (Bureau of the Census, U. S. Department of Commerce, *General Social and Economic Characteristics: Michigan*, PC(1) -C24, April 1972, Table 124.)

Similarly, interviews with staff at hospital emergency rooms and outpatient departments, offices of the Social Security Administration (where SSI certification takes place), and schools revealed that they generally did not take the opportunity to refer children who might qualify for Medicaid to a place for certification. Sometimes staff did not even know the criteria a child must meet to qualify for Medicaid. Rarely did they know specifically about Medicaid benefits, including EPSDT.

Screening Children According to Their Need

According to EPSDT requirements, states have an obligation to screen all Medicaid children at regular intervals according to their age and need. Clearly, the system a state uses for identifying when children should be notified or given screening appointments affects whether this obligation is fulfilled properly. The states we visited used a variety of approaches, all of which missed needy children.

Following policy guidance given by HEW in 1972,[28] three of our study states (Michigan, Mississippi and South Carolina) set a numerical goal of reaching a certain percentage of eligible children each year.[29] While setting and reaching numerical targets make good sense, targets must be related to the screening needs among eligible children. Not only were the target rates sometimes inappropriate, but in some places we found that systems for determining which children would be reached to meet the goals bore little relation to need.[30]

Nowhere except in Genesee County, Michigan, were names sent for outreach related to children's age or to their need for screening. In Mississippi, counties were sent an alphabetical listing of all eligible children semi-annually. The county health department then gave appointments to children in alphabetical order, ignoring children's relative health needs. Parents were not aware that they could request and receive screening for their children regardless of the first letter of their last name.

Some states have devised procedures to identify and not reach out to children who are receiving "equivalent care."[31] These procedures, however, have excluded a large number of children who need to be screened. They were time-consuming and ineffective, besides.

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[28] HEW recommended a goal of screening one-third of all eligible children each year. See memorandum to: "All SRS Regional Commissioners, Establishment of Target Goals for Numbers of Children Screened and Development of a Timetable for Reaching Those Goals," Field Staff Information and Instruction Series, No. 87, November 17, 1972, Medical Services Administration.

[29] In Michigan and Mississippi, the annual goal was 50 percent and in South Carolina, it was 33 percent.

[30] For the ages at which the American Academy of Pediatrics recommends children be screened, see Table 8 in Chapter 4 of this report.

New Jersey developed a computerized system for identifying children assumed to be receiving adequate care and for targeting outreach on those who were not. However, on the basis of the state's definition of adequate care, *90 percent* of all eligible children were found not to need EPSDT, and all school-age children were automatically considered under adequate care.[32]

Such targeting of outreach resources has not produced greater efficiency in reaching the neediest children. An eligible child's chances of being screened were no greater when targeted for special outreach efforts than when determined already receiving adequate care. And in both cases, the proportion reached was pitifully small. The state's data reporting system showed that 4.6 percent of the children specially identified and targeted for outreach efforts were screened, compared to 4.4 percent of the eligible children who got no special outreach.[33] The entire targeting system resulted in screening only *one-half of one percent* of the total eligible children in eight months. As one child advocate in New Jersey observed, "They are spending more money trying to prove that particular children don't need care than to serve them."

In Suffolk County, New York, the attempt to sort out children who were receiving equivalent care and to target outreach resources appeared largely ineffectual. Efforts were made to document care received by physicians,[34] but two-thirds of the eligible children were totally unaccounted for--neither screened, nor receiving equivalent care, nor refusing services.[35]

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[31] States retain responsibility to screen and treat children unless they have received comparable care from providers who are not EPSDT providers. To date, HEW has not issued a policy directive explaining to states what documentation is needed before assuming that a child does not need screening.

[32] In early 1975, 338,000 children of the 375,000 fell in this category. (Interview with Chief, Bureau of Child Health Services, Division of Medical Assistance, New Jersey Department of Institutions and Agencies, Trenton, New Jersey, 26 November 1975.)

That this great a proportion of children should not need EPSDT services is difficult to believe, given that the immunization rates for the region which includes New Jersey are as low as the rest of the nation (e.g., nearly 30 percent of youngsters (age 0-19) "in poverty" are inadequately immunized against polio). (Center for Disease Control, *United States Immunization Survey: 1975* (Washington, D.C.: HEW, June 1976), Table 5.)

[33] Figures derived from data from the Division of Medical Assistance and Health Services, "EPSDT Statistical Report for June 1975," Table 2, August 21, 1975; and "EPSDT Statistical Report for September 1975," Tables 2 and 4, November 14, 1975, Department of Institutions and Agencies, State of New Jersey, Trenton, New Jersey.

Making Screening Services Accessible and Acceptable

Knowing about EPSDT and establishing eligibility are necessary but not sufficient to assure that children receive services. A host of other factors can cause children to go without care. Is screening offered at a place the family can get to? At a time that does not cause the parent to lose a day's pay or the child to lose a day of school? By people whom the family trusts and is willing to go to for screening or follow-up health care?

Federal policy statements emphasized the fact that some families will need help in using EPSDT services:

> (1) in understanding the importance of preventive health services and early diagnosis and treatment; (2) in overcoming their fears of doctors and other apsects of medical care; (3) in mobilizing themselves to make use of a health service for which they may feel no pressing need; and (4) in arranging for transportation, baby-sitting services or other services to enable parents to bring children to the screening center or to other providers of health services. Parents who are burdened with other family problems and financial stress may not be able to make much effort to seek screening examinations for their seemingly well children.[36]

One responsibility of the state agency administering EPSDT is to help families make arrangements to use EPSDT services.[37] Among the most common problems faced prior to screening and for which families may need help are: (1) finding acceptable sources of care; (2) arranging for transportation to and from the health care provider; and (3) making appointments and rescheduling them when they are broken.

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[34] The New York system provided for the local welfare office to obtain written documentation from a physician that an eligible child had received all preventive health care (including physical examinations, immunizations and laboratory tests) that the physician judged appropriate. Physicians received $5 for completing the form.

[35] Medical Assistance Administration, "CHAP Progress Report, March-October 1975" (State of New York: Suffolk County Department of Social Services); and "Statistical Report on Children Receiving Periodic Health Examinations" (Form DSS 2404), November 1975, December 1975, January 1976 and February 1976 (State of New York: Suffolk County Department of Social Services). (Xeroxes.)

Immunization data confirmed that children in Suffolk County who needed screening were missed: 25 percent of children entering day care centers in the county were incompletely immunized; yet less than 1 percent of children screened under EPSDT were found in need of an immunization. (Bureau of Disease Control, *School Enterer's Immunization Status Survey, School Years 1974-75* (New York: State Department of Health, undated), p. 91). Based on nationwide data, one can assume that Medicaid children entering day care are even less well immunized than the total group of children entering day care.

[36] *Medical Assistance Manual*, Part 5, 5-70-20(D)(3)(d).

[37] States must inform recipients of the names and location of providers offering services, and of transportation services available under the state plan. They must also take steps to assist recipients to receive screening services, normally within 60 days of a request. (45 C.F.R. §205. 146(c)(ii).

Trusted Sources of Care

> Who the sponsoring agency is and whether people think it "cares" are the things that matter to people when they decide whether or not they want to use a program,

said the Director of the Statewide Coalition for Child Care in New Jersey.

> Community-based, personalized health services are what people like and will use. Even private doctors are getting to be as bad as clinics--you wait forever and sometimes they won't take Medicaid patients or treat them like it's such an effort.

The way parents and children were talked to and treated and what the clinic was like were all important factors in an EPSDT program. We found that the quality of these intangibles varied widely. Some professional personnel were sensitive to the special needs of poor families; others were not. Some recipients were satisfied; some resentful. In Genesee County, Michigan:

> The health department has treated me nice...EPSDT is something we really need, that is helping us.

In Suffolk County, New York:

> It's a terribly demoralizing experience and you feel like you are part of a test program. Everyone is very skeptical.

In Oktibbeha County, Mississippi:

> Even people who need services won't go to the Health Department because they don't want to be treated like that. It's a hostile place to poor folks.

It is clear that EPSDT will not reach poor children unless services are offered by providers who are trusted and accepted by the communities they serve.

Operation Life, Inc., described earlier in this chapter, illustrates this point. When it began screening, it was one of a number of providers in Las Vegas offering EPSDT services to eligible children. By the end of its first year, its popularity made it the primary source of screening in the city. As Mrs. Ruby Duncan, Chairperson of Operation Life, has stated, the high rate of participation can be explained by two principal reasons: (1) the clinic is located in the heart of the poverty community; and (2) the current and former welfare mothers who go door-to-door explaining EPSDT, arranging for transportation, and even helping a busy mother dress the children for the trip to screening, develop a relationship that ensures success.

> It is a communication of mother to mother, poor person to poor person which involves trust, understanding and a unique chemistry that cannot be duplicated

> by brochures, TV announcements, suspect welfare division employees or "foreigners" to the community.[38]

Transportation Assistance

> Fewer than 10 percent of Medicaid people in Florence County have their own transportation. Florence County itself has a small bus line with about four buses in the whole line. They're really uncomfortable and the schedules are unpredictable. So that's what most people are up against when they have to go to the doctor or clinic.

As this Neighborhood Services worker told us, it is increasingly clear that for many families the key to being able to use EPSDT services is getting transportation help. A small survey of Medicaid recipients performed in Wayne County, Michigan, showed that "no transportation" was the second most common reason for missed appointments and accounted for nearly 10 percent of the families who were unable to keep their appointments.[39]

This problem is addressed in Medicaid regulations. State Medicaid plans must include ways to assure needed transportation to and from medical services,[40] and to explain to recipients who request screening services what transportation services are available under the state plan.[41] States have a range of options, though, as to how to assure transportation services. They can:

(1) offer transporation as an item of medical assistance and reimburse the provider;

(2) count transportation as an item of assistance in determining a welfare recipient's cash allowance;

(3) provide it directly and count it as an administrative cost; or

(4) arrange with local volunteers to assist families.

Federal policy is explicit that "arranging" for transportation does not mean that states must "pay" for it.

Arrangements for transportation in our study sites ranged from quite good to quite bad. In each of the states, the Medicaid plan covered payment of emergency ambulance service. But:

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[38] Anderson, "The EPSDT Program: An Opening in the Health Industry for CDCs and Other Community Organizations," p. 17.

[39] "EPSDT Client Survey" (Wayne County, Michigan: Research and Statistical Analysis Unit of the Wayne County Department of Social Services, undated mimeographed report), p. 8. An evaluation of four EPSDT Demonstration Projects concluded that transportation is an "essential component of each project." *First Quarterly Evaluation Report of the EPSDT Demonstration Projects* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, November 1974), p. 5.

[40] 45 C.F.R. §249.10(a)(5)(ii).

[41] 45 C.F.R. §205.146(c)(ii)(A).

- Mississippi paid for no other transportation services and required families to rely on arrangements with volunteers, friends or relatives to fill the need.
- The New York plan, at the opposite end of the spectrum, allowed reimbursement for medical transportation without restriction, as long as authorization was obtained beforehand.
- The New Jersey plan mentioned only payment for special transportation for individuals unable to use public conveyances.
- Michigan reimbursed transportation to medical service only under particular situations, including for EPSDT screening and one treatment visit, and for ongoing treatment visits by blind and disabled persons receiving SSI benefits.
- South Carolina allowed reimbursement if free transportation could not be arranged, and it had a special provision for EPSDT transportation.

These policies meant that parents and children in Oktibbeha and Essex counties had a very difficult time using EPSDT if they needed transportation help.

Florence, Suffolk and Genesee counties' special transportation assistance to screening services was worthy of note. In Florence County, South Carolina, the welfare department contracted with the Community Action Agency, which had vehicles and drivers. The caseworker scheduling a family for screening arranged with the Community Action Agency for needed transportation. Suffolk County, New York had clerks who authorized requests for transportation and reimbursed cab companies or private persons who submitted claims for driving an EPSDT recipient. Genesee County, Michigan had an EPSDT transportation unit staffed by four transportation aides to drive needy families to the screening clinic in state-owned cars. Transportation aides worked closely with those who followed-up appointments. In each of these places, we were told that transportation was a crucial link to the EPSDT program, and if there were complaints, it was that there were not enough transportation services for all who needed them.

Making and Breaking Appointments

A high rate of broken appointments has been a problem in EPSDT programs around the country. In some places the rate is as high as 50 percent. Sometimes broken appointments cannot be avoided. But sometimes they can, and support services often make the difference.

Although we found some areas where support services were provided in an exemplary way, in too many instances, appropriate assistance simply was not provided. In some places practices actually hindered a family's ability to get to screening.

For example, in Oktibbeha County, Mississippi, the Health Department made screening appointments for children without ever finding out from the families when it would be possible for them to come. Health Department staff sent postcards to eligible families notifying them of the date and time their child was expected for screening. Because postcards were sent to families in alphabetical order, they may not have meant much to the family--it may have been one or several months since they had heard about EPSDT at welfare certification.

In Mississippi, families were not routinely offered help in getting to the clinic. Instead, a list of families with appointments was sent to the welfare department ten days in advance of when each screening clinic was held. The caseworkers reviewed the list and if they saw the name of a client whom they knew would have difficulty getting to the appointment, they sometimes called and offered assistance. In Oktibbeha County, only about half of the appointments for screening were kept.

In contrast, caseworkers in Florence County, South Carolina visited eligible families at home and explained the screening services the child would get. The worker also filled out a health history form on each child, scheduled an appointment and arranged for transportation if it was needed. About a week before the appointment, the worker either visited again or telephoned to remind the family about the appointment. These same workers were also at the clinic itself, prepared to make a telephone call, or even a home visit, if a family did not come for the appointment. In Florence County, 96 percent of all appointments for screening were kept. As one of the workers told us, "If we simply gave them an appointment, they wouldn't show up ...the people you really want to reach are the ones who can't do it on their own."

What happens to the children who missed their appointments? If there was no mechanism to follow up and help them get to the screening, the family was lost to the system. Efforts expended on initial outreach were wasted. Despite this, we found that follow-up systems existed only in the states that used health departments for screening--perhaps because all children were screened in one place, it was relatively simple and inexpensive for staff there to note broken appointments as they occurred and initiate follow-up.

The problems of following up missed appointments in New York and New Jersey were quite different because numerous providers were used for screening and most did not have staff for follow-up. In New Jersey, the task was particularly difficult because of the relatively large number of children to keep track of. At the time of our visit, the Essex County welfare office had to wait anywhere from 45 to 90 days for a copy of a screening claim filed by the provider. If a claim was not received, the caseworker was supposed to contact the family. If she did not, nothing happened until six months later, when the computer issued another form indicating outreach was again necessary.[42] In Suffolk County, staff simply had no way to know when appointments with private physicians were not kept.

Recommendations

1. While we believe that needy children who cannot obtain services due to Medicaid eligibility policies should be made eligible for care, we recommend that the first order of business for Congress and HEW must be to make necessary legislative and regulatory changes so that at least children who are currently eligible are assessed and get needed follow-up care.

In addition, Congress should modify Medicaid eligibility for individuals under age 21 to eliminate the most inappropriate exclusionary policies. As a minimum step, eligibility for Medicaid should be extended to all individuals under age 21 who meet states' financial eligibility standards regardless of family status or other characteristics. According to estimates by HEW, these children number approximately 1.8 million, of whom only about .4 million are currently certified for Medicaid. Thus, a requirement for states to cover all financially needy children would make an additional approximately 1.4 million needy children eligible and would erase one of the most destructive practices of the program--that of penalizing poor families for being intact.

Even if Medicaid eligibility is expanded, since there will be lag time before the change is implemented, HEW must guide states during the interim about coverage for subgroups of financially needy children. The ruling by HEW's General Counsel, that states which opt to cover financially needy individuals under age 21 must cover all such individuals and cannot cover special subgroups of them, should be reconsidered immediately and reversed.

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[42] Subsequently, a state official wrote us that local systems for case management had been developed because the 90-day limit violated the federal requirement for documentation of diagnosis and treatment services within 60 days of screening. (Letter from Arthur T. Mellin, M.S.W., Bureau of Child Health Services, Division of Medical Assistance and Health Services, Department of Institutions and Agencies, State of New Jersey, Trenton, New Jersey to Children's Defense Fund, 8 July 1976.)

The change should be conveyed to regional offices and the states.

2. HEW should encourage that outreach for EPSDT be performed by community-based organizations.

   a. In addition to maintaining the federal reimbursement arrangements for EPSDT outreach services performed by public agencies, Title XIX should be amended to provide a national average of 90 percent federal reimbursement (the exact federal shares among states would vary as they do now for medical services under Medicaid) for outreach by private, nonprofit, community-based organizations whose board of directors is composed of a substantial number of poor persons and their representatives (e.g., Head Start programs and community clinics).

   b. The current Medicaid requirement that staff performing administrative support services, such as outreach, must support skilled medical personnel should not apply to EPSDT outreach and follow-up services.

   c. HEW should provide strong encouragement and guidance to states to contract with community-based organizations for the provision of EPSDT support services.

   d. HEW should clarify policy so that such organizations performing EPSDT outreach can receive names of children on Medicaid or of eligible children needing assessments.

   e. HEW should provide such organizations with information about negotiating contracts with state agencies in order to perform EPSDT outreach. HEW should also inventory and make available to states lists of available sources of public service employment (e.g., CETA, WIN, youth employment programs) which can be used for EPSDT outreach and other support services.

3. HEW should issue one consolidated set of regulations for informing eligible families of EPSDT services.

   a. To assure that families receive the most basic information about their rights under the program, states should provide annual written notice to all families with Medicaid-eligible children. The notice should spell out clearly what a child is entitled to under the program and how to obtain services. It should explain the right to a fair hearing and legal avenues of appeal if families believe their children's rights have not been fulfilled.

   b. Federal standards should be set establishing acceptable levels of performance for EPSDT outreach. The standards should be in terms of number of assessments performed and should represent a reasonable proportion of needed assessments actually provided to Medicaid-eligible children. Standards should be established for children in four age groupings: 0-3, 4-6; 7-12; and 13-21; taking into account the different needs for assessment.

c. States which meet federal performance requirements (e.g. a reasonable percent of needed assessments have been performed) should have flexibility to perform outreach according to the method of their choosing. However, they may not institute outreach policies which deny a recipient the right to arrange for assessments directly.

d. In localities where federal performance standards are not met, the states should be required to develop a new outreach program, emphasizing the use of persons and organizations from the poverty community. The plan should be subject to approval from HEW.

e. The regulations must make explicit that EPSDT is a voluntary service and that no state may use coercive techniques.

4. Federal EPSDT reporting requirements should be revised to include reporting on:

a. the number of children eligible and the assessments provided by age groups: 0-3, 4-6, 7-12 and 13-21; and

b. the number of assessments provided that were initial, second, third or more.

5. State Medicaid programs should reimburse, as an EPSDT administrative cost, for certain minimum reporting by providers who give services to Medicaid-eligible children but are not reimbursed by Medicaid for providing them. A provision should be added to the legislation which authorizes each federal health program providing primary care to poor children (e.g., programs of the Public Health Service Act and the Social Security Act), requiring them to report to the state Medicaid agency selected information needed to manage the EPSDT program (e.g., on the assessments and follow-up care provided to Medicaid-eligible children).

6. HEW should provide state and local EPSDT administrators with technical assistance in identifying special groups of children who have not been reached (for example, children on SSI, in foster care, or the medically needy) and in planning outreach efforts to reach them.

7. State and county EPSDT administrators should make sure that the variety of local agencies and places known and used by the Medicaid families have sufficient information so that they can help spread the word about EPSDT informally. For example Head Start programs, Community Action Agencies,

Legal Services offices, hospitals, housing projects, laundromats and the like should have posters and written materials explaining broadly who can qualify for the program. State and local Medicaid agencies should provide workers in such places with basic information so that they know what the program offers, how it works locally and where services can be obtained.

8. State and local EPSDT administrators should conduct needed training to assure that providers understand how to help a child establish Medicaid eligibility. Staff at hospital emergency rooms, hospital outpatient clinics, school health centers and so on should routinely inquire about the child's need for EPSDT and refer interested parents to a source of EPSDT services.

9. The EPSDT component of state Medicaid plans should include measures to assure children can get assessments as needed. Plans should demonstrate adequate transportation arrangements, a system for scheduling appointments when they are convenient for families, effective measures for rescheduling missed appointments, and assurances that there are providers of assessments who are acceptable to the community.

Chapter 4

Screening: The Net That Catches Health Problems

To most people, screening means "the use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive study of their physical or mental problems."[1] If screening were performed early in a child's life and at regular intervals, a significant portion of health problems would be caught, prevented or corrected. The architects of EPSDT estimated that

> a program that screened children at ages 4 days, 1 year, and 3, 5 and 9 years, and provided appropriate follow-up and treatment, could prevent or correct 40 percent of vision and hearing defects and 20 percent of other chronic handicapping conditions.[2]

Although the term "screening" was used from the start, neither the framers of EPSDT nor the Congress in enacting the program defined what screening should consist of. Not until five years after EPSDT's enactment did HEW guidelines define screening. They recommended that screening include a health and developmental history, an unclothed physical including a heart examination, vision and hearing testing, an assessment of immunization and nutritional status, and various laboratory tests.[3] (For a list of the recommended screening components, see Table 1.)

These guidelines revealed the deep-seated ambivalence about screening that plagued EPSDT from the start. On the one hand, they reflected a commitment to screen efficiently and inexpensively by aiming at those conditions that can be found by a single, rapid test or procedure, in settings with large

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[1] *Medical Assistance Manual*, Part 5, 5-70-20(A)(1).

[2] "Maternal and Child Health Care Programs," (Washington, D.C.: Office of the Assistant Secretary for Program Coordination, HEW, October 1966), p. v.4.

[3] These include a hemoglobin or hematocrit determination to test for anemia, a tuberculin test, blood tests for lead poisoning and a test for the sickle trait in black children.

Table 1

MINIMUM RECOMMENDED COMPONENTS
OF A SCREENING PROGRAM

1. Health History
2. Physical growth (height, weight, head measurements)
3. Developmental assessment
4. Unclothed physical inspection
5. Ear, nose, mouth and throat inspection
6. Vision testing
7. Hearing testing
8. Anemia test
9. Sickle cell test
10. Tuberculin test
11. Urine screening
12. Lead poisoning screening
13. Nutritional status
14. Immunization status
15. Other screening tests as appropriate (e.g., chest x-ray, cardiac scan, blood pressure)

Source: *Medical Assistance Manual*, Part 5, 5-70-20(E)(7).

numbers of children, by personnel less highly trained than physicians. The vision, hearing and laboratory tests fall into this category.

But on the other hand, the guidelines also called for procedures which are done on an individual basis and which are time-consuming, e.g., health histories, unclothed physical examinations and reviews of growth and development. These reflected the understanding that screening strictly defined was not adequate to uncover certain problems that might impair children's health. Thus, EPSDT was to go beyond a narrow screening toward a more individualized *health assessment*.

The ambivalence between these two concepts--a narrow screening and a comprehensive health assessment--had a serious consequence. Without clear guidance from HEW (which never converted its recommendations into requirements), states have generally focused on providing services that can be done simply and inexpensively. As we will show later in this chapter and in Chapter 6 on developmental assessment, the more individually-oriented parts of the screening package were performed less often and less well than other parts.

What the Data Show

One thing screening data make clear is that most children screened by EPSDT are suffering from health problems and desperately need the services of EPSDT. Nationally, for every three screenings, two conditions needing follow-up care were found.[4] Between 60 and 80 percent of problems found in screening were previously unidentified or not being cared for.[5] In our study sites, as

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[4] See Appendix F, Table 1, for number of screenings and total conditions found for fiscal years 1975 and 1976.

[5] Harry W. Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975* (San Antonio,

Table 2 shows, the prevalence of problems found varied--from a high in Oktibbeha County, Mississippi (where for every two screenings, three conditions were found) to a low in Florence County, South Carolina (where for every five screenings one condition was found).[6]

Screening found that children suffered from a host of different problems. Among the most common for Medicaid-eligible children in the nation as a whole were inadequate immunizations, dental problems, low hemoglobins (which most often indicates iron deficiency anemia), vision difficulties, upper respiratory problems, elevated lead levels in the blood, genitourinary infections and hearing problems. (See Table 3 for the percent of children screened through EPSDT who had these problems.) Special studies of EPSDT found that, in addition to these, skin problems (e.g., impetigo), parasites (e.g., pin worms), orthopedic problems and problems with the heart and circulatory system were also common.[7] CDF study counties reported that children also had neurological problems, speech difficulties and problems of growth and development.[8] (For the prevalence of conditions among children in our study sites, see Table 4.)

When we looked closely at referrals made, according to the age of the child screened (see Tables 2 and 4), we found that in each of our sites (except for Essex County where we could not get figures by age groups) a higher percentage of referrals were made for children

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Texas: Health Services Research Institute, University of Texas Health Science Center, January 1976), p. iv.

[6] We have not included Suffolk County in this range--which appears to have referred the fewest conditions--because there is obviously something wrong with the data reported by Suffolk County. The reporting form used (New York State Department of Social Services Form DSS-2404, August 1974) clearly asks for the number of *children* referred for one or more conditions, and it also asks for the number of *children* for whom no referable conditions were found. Separately, the form asks for the total number of referable conditions found. Despite the nearly 600 children screened per month, these forms never showed a case where even one child was referred for more than one condition. It is highly improbable to find conditions distributed across 13 separate diagnostic categories and *never* find a child with two conditions. Even if the conditions were statistically independent in the population screened (and it is more likely that children with one disorder will also have others), more children with at least two conditions each should have been found.

We can only conclude that Suffolk has reported each child only under a single positive test result, no matter how many conditions in fact were found. See Appendix K for sources of data on conditions referred in our study sites.

[7] Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975*, p. 46 and following.

[8] While each of our study counties except for Essex reported on conditions beyond those minimally required by HEW (hearing, vision, dental, lead and other), the data are not comparable because states selected different conditions (and definitions of them) on which to report. Therefore, we have not included in this chapter figures from our study sites beyond those which are clearly comparable, shown in Table 4. Additional figures are in Appendix K.

Table 2

EPSDT REFERRALS IN CDF STUDY SITES

	Referrals Per Screenings		Number of Conditions Found Per Screening and Per Child Referred in CDF Study Sites	
	Number of Screenings	Referrals Per 100 Screenings	Conditions Per Screening	Conditions Per Child Referred
Florence County, South Carolina				
Total	669	18.8	.221	1.175
Age 0-6	297	8.4	.094	1.120
Age 6-21	372	27.2	.323	1.188
Genesee County, Michigan				
Total	8,466	60.0	.894	1.491
Age 0-6	3,685	55.1	.900	1.634
Age 6-21	4,781	63.7	.889	1.396
Oktibbeha County, Mississippi				
Total	1,014	94.5	1.528	1.617
Age 0-6	216	92.6	1.523	1.645
Age 6-21	798	95.0	1.529	1.609
Suffolk County, New York				
Total	3,198	11.8	.118	1.000
Age 0-6	1,895	10.2	.102	1.000
Age 6-21	1,303	14.1	.141	1.000
Essex County, New Jersey[1]				
Total	4,082	47.6	.551	1.158

[1] Age breakdown not available in source document.

Source: See Appendices J and K.

Table 3

SELECTED NATIONAL DATA ON PREVALENCE OF HEALTH PROBLEMS IN POOR CHILDREN[1]

	Percent of Children Found With Condition By Selected National Studies[2]	Percent of Children Found With Condition According to National EPSDT Data[3]	Percent of Children Found With Condition By Special EPSDT Projects[4]
Vision	10.6[5]	10	13 (of children screened for vision) 10 (of total children screened)
Hearing	13.4[6]	3	9 (of children screened for hearing) 7 (of total children screened)
Dental	90-100[7]	25	25
Lead Burden	1.5-5.0[8]	9 (in urban areas)	
Immunization	39.9 (Polio)[9]		
	27.2 (DTP)[10]	50	23.6-62.2
Hematocrit (most often indicates anemia)		12	13
Upper Respiratory		8	
Genitourinary		7	

[1] The information in this Table must be interpreted cautiously. Because there are so few reliable national data on the prevalence of health conditions, and because, even if there were, many factors in various localities could legitimately cause deviations from them, rates from existing data should not be considered as norms for EPSDT referrals. Rather, these rates should be viewed as rough reference points.

[2] This column must be interpreted with particular care. Existing studies show that the prevalence of these conditions in children varies tremendously by age, income, sex and race. We have selected figures which must be adjusted before national or local prevalence rates could be extrapolated.

[3] These figures come from Medical Services Administration, "EPSDT: The Possible Dream" (Washington, D.C.: Social and Rehabilitation Service, HEW, February 1977), p. 1.

[4] These figures are from Harry W. Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975*, pp. iv and 56.

[5] This is the rate for eye infections and functional abnormalities for children ages 12-17 living in families with incomes of less than $5,000. (Vital Health Statistics, "Eye Examination Findings Among Age 12-17, United States" Rockville, Md.: National Center for Health Statistics, Publication #HRA 76-1637, November 1975.)

[6] This rate is for children ages 12-17 with abnormalities of the right eardrum only, living in families with annual incomes of $3,000-$4,999. (Vital Health Statistics, "Hearing Sensitivity and Related Medical Findings Among Youth 12-17 Years, United States" (Rockville, Md.: National Center for Health Statistics, Publication # HRA 76-1636, November 1975), Table 14, p. 43.)

[7] According to the American Academy of Pediatrics, "after age three nearly all children have dental disease...." Frankenburg and North, *A Guide to Screening for the EPSDT Program Under Medicaid*, p. 105.

[8] These figures are based on the fact that at least 10 percent of children ages 1-6 live in places containing loose or peeling lead paint, and of these, between 15 and 50 percent have elevated lead levels in their blood. Frankenburg and North, *A Guide to Screening for the EPSDT Program Under Medicaid*, p. 188.

[9] Of the population aged 0-19, not adequately immunized. Center for Disease Control, *United States Immunization Survey: 1975* (Atlanta, Ga.: Public Health Service, HEW, June 1976), Table 4.

[10] Of the population 0-13, not adequately immunized. Center for Disease Control, *United States Immunization Survey: 1975*, Table 5.

Table 4

CONDITIONS FOUND IN CDF STUDY SITES, BY TYPE, PER 100 SCREENINGS

	Vision	Hearing	Dental[2]	Lead Burden[2]	Immunization[2]	Hematocrit[2] (Most often indicates anemia)
Florence County, South Carolina						
Total	1.8	1.0	14.6	-	-	-
Age 0-6	0.0	.3	4.0	-	-	-
Age 6-21	3.2	1.6	23.1	-	-	-
Genesee County, Michigan						
Total	8.6	1.9	-	1.2	15.2	2.1
Age 0-6	1.9	.7	-	2.7	32.6	4.0
Age 6-21	13.7	2.8	-	0.0	1.8	.7
Oktibbeha County, Mississippi						
Total	5.3	1.1	74.2	-	-	11.2
Age 0-6	.9	.9	39.4	-	-	29.2
Age 6-21	6.5	1.1	83.6	-	-	6.4
Suffolk County, New York						
Total	0.0	.3	.4	.0	.7	.2
Age 0-6	0.0	.4	.3	.0	.8	.2
Age 6-21	0.0	.1	.7	.0	.7	.3
Essex County, New Jersey[1]						
Total	8.7	5.0	8.6	1.2	-	-

[1] Age breakdown not available in source document.

[2] Blanks indicate no separate data available for condition at that site. The test results may have been combined with other unlisted categories or the test may not have been given at all.

Source: See Appendix K.

between the ages 6-21 than for those under age 6. While the unmet health needs of children of school age were great, the lower referral rate among younger children did not necessarily mean their needs were better met.

There were several reasons why there were so few EPSDT referrals during children's earliest years when preventive health care had greatest payoffs. Sometimes a certain screening procedure was not appropriate for very young children. For example, dental screening and some visual acuity and auditory tests cannot be done until the child is approximately 3 years old. Because the 0-6 age group includes a large portion of children under age 3, referral rates for this group should be lower than for groups of older children.

But other times, many preventive therapies needed by very young children were not included in EPSDT and did not show up as referrals. For example, careful review of diet, floridated vitamin supplements where drinking water lacks protective flourides, or parent counseling about avoiding accidents rarely were done. Only the consequences of their omission showed up as EPSDT referrals later in the child's life (e.g., when cavities afflicted second teeth).

While some variation in referral rates by age is to be expected, we found enormous variation by place and by type of condition referred--variation too wide to be explained by differences among children or among regions of the country. For example, referrals following screening ranged from a low of 18.8 per 100 screenings in Florence County, South Carolina, to a high of 94.5 per 100 screenings in Oktibbeha County, Mississippi (see Table 2). Referral rates for particular kinds of conditions also varied markedly. Take referrals for visual acuity as a simple example. The national average of referrals for problems is 8.5 per 100 screenings. In 1975, North Dakota referred 31.2 visual acuity problems per 100 screenings, while South Dakota referred only 4.4. Clearly the health status of poor children in these two adjacent states did not differ as much as could explain these disparate referral rates. Ratner, EPSDT data were reflecting, in part, substantial differences in how well screening was carried out.

Several conclusions can be drawn about the kinds of referrals in our study sites when compared to national data on the prevalence of health problems in children.[9] (See Table 3.) Except in Oktibbeha County, Mississippi (and perhaps in Genesee County, Michigan, where data on dental referrals were not available), programs in CDF study sites were failing to refer children for needed dental care.[10] In Genesee and Suffolk counties, referrals for anemia were much lower than national prevalence data would indicate and, except in Essex and Genesee counties, vision referrals were extremely low. Suffolk County's referral rates for immunization and hearing problems were also well below the national average.[11] Similarly, referrals of 1.2 percent in Essex County for elevated blood lead levels are suspiciously low, especially for a large urban area such as Newark, New Jersey.

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[9] See Appendix F for a discussion of the limitations and difficulties in comparing county referral data to national data.

These data from EPSDT screening should be interpreted cautiously. Children's health does vary somewhat from place to place, with their families' income levels and ethnicity, and according to the health resources available to them. The assessments themselves have error rates and we do not have reliable standards (other than national averages on certain conditions from one or two sources) against which to judge specific counties' statistics. But the wide variation we found indicates that the administration of screening and the consequences for children in the EPSDT program differed markedly. The variations began to be explained as we looked more closely at how the several important components of screening were implemented in each of our study sites.

Health Histories and Parental Involvement

Obtaining a thorough health history is crucial in identifying a child's health needs. According to one expert, "90 percent of diagnosis is based on history....Consequently, in screening, the absolute importance of interview data in discovering untreated problems is undeniable."[12]

Federal EPSDT guidelines recommend that a health and developmental history (e.g., a check sheet) taken from the parent or other responsible adult familiar with the child, be part of a screen.[13] While the guidelines did not define what constituted an adequate history, the EPSDT *Guide* prepared by the American Academy of Pediatrics suggested several standard interviews.[14] In the states CDF studied, however, providers rarely met the AAP's standards for adequate health histories.

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[10] National EPSDT data show that 25 percent of children are referred for dental care. But even that figure seriously underestimates the percent of children who should be referred. According to the American Academy of Pediatrics, "after age three nearly all children have dental disease ...." (William K. Frankenburg and A. Frederick North, *A Guide to Screening for the EPSDT Program Under Medicaid*, prepared by the American Academy of Pediatrics (Washington, D.C.: Social and Rehabilitation Service, HEW, 1974), p. 105.) Thus, EPSDT guidelines state: "Extensive dental screening is unnecessary since almost all children have some dental problems and definitive dental diagnoses and treatment will usually be necessary." (*Medical Assistance Manual*, Part 5, 5-70-20(E)(7)(e).)

[11] According to a report by staff of the Suffolk County Department of Social Services, figures on referrals are considered low, since the billing forms are often delayed in reaching the EPSDT Control Unit.

[12] A. Frederick North, "Screening in Child Health Care: Where Are We Now and Where Are We Going," *Pediatrics*, Vol. 54 (November 1974), p. 635.

Of all CDF's study sites, Mississippi did the least well at getting the necessary health information. Its brief form omitted questions about prenatal, birth or family health problems, and rather than ask about specific illnesses or symptoms, it relied exclusively on several open-ended questions such as "Is there any condition you want the nurse to know about?"[15] Furthermore, Mississippi, with its alphabetical system of notifying families for screening appointments, made no attempt to arrange appointments for times when parents could come in with their children. When parents did not accompany young children, vital health information that only parents could have provided went totally unrecorded.

In terms of content, Michigan had the most complete health history forms used in screening, with a different one for children under and over the age of 6. But even with the best of forms, there were problems. A caseworker from the Department of Social Services was supposed to bring the form to families before the screening appointment to help parents fill it out. But a Genesee County official told us that the workers rarely had time to help families complete the forms. Transportation aides and screening clinic nurses said that many families forgot to bring the form with them or had filled it out incorrectly. When that happened, the nurse asked the mother to fill out a new form while the child was being screened, but nurses with whom we spoke specifically mentioned the difficulty of having to do the physical examination without having the health history in advance.

South Carolina's "Health Record" was extremely superficial.[16] Aside from a question asking about "previous illness or accidents," no other information was requested about symptoms, problems or other relevant health conditions. To make matters worse, in most counties, emphasis was placed on getting children to screening even if it meant not having the parent accompany them. As a result, health histories often were not obtained, except in Florence County, where the Health Department had trained welfare caseworkers to take health histories. During a home visit they filled out the histories and brought them to the Health Department prior to a child's screening.

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[13] *Medical Assistance Manual*, Part 5, 5-70-20(E)(7)(a).

[14] See Frankenburg and North, *A Guide to Screening for the EPSDT Program Under Medicaid*, Appendix 1, "Questionnaire Forms," pp. 199 and following.

[15] While open-ended questions are a valuable way to elicit information about a child's developmental and health history, they alone are not adequate for obtaining needed information about a child's medical history. Parents do not always remember what illnesses, for example, a child has had unless asked them by name.

[16] State of South Carolina, "Child and Youth Health Record" (Form DHEC 1804, Rev. 7-71). South Carolina state health officials acknowledged the inadequacy of the form and were in the process of revising it at the time of our visit.

In New York and New Jersey where a variety of providers screened children, they used whatever health history forms they judged to be appropriate. Both states recommended including a health history as part of a screen, but neither evaluated the extent to which histories were taken, the adequacy of the forms used or the involvement of parents in supplying vital information.

The Screening Package

As we said earlier, HEW guidelines recommended a minimal set of procedures to constitute a "screening package." (See Table 1.) And while regulations required that states define a screening package, the recommended set of procedures were not required for several reasons.[17] Prior to 1970, little attention from the medical establishment had been devoted to the question of what screening procedures should be routinely performed to identify health problems of children. When it came time to develop EPSDT regulations and guidelines, there was no professional consensus about what a screen should consist of.[18] In addition, the prevailing

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[17] "Effective implementation of the EPSDT program requires that the state agency specify the content of the screening package" because regulations 45 C.F.R. §249.10(a)(5) "require that the amount and/or duration of each item of service provided under the State plan be specified in the State's Title XIX plan." (See numbers 4, 6 and 7, *Medical Assistance Manual*, Part 5, 5-70-9.00, "Answers to Questions".)

[18] It should be noted that when HEW issued these recommendations in June 1972, it said it was consulting with authorities to decide whether it would be appropriate to mandate a minimum package of screening procedures. In EPSDT regulations proposed August 20, 1975, the Department set forth a required package consisting of:

- health and developmental history
- unclothed physical examination
- determination of immunization status
- visual screening
- hearing testing
- laboratory procedures appropriate for age and population group
- nutritional status assessment
- criteria for dental screening and referral clearly and specifically stated, or direct referral to a dentist without preliminary dental screening.

These regulations, however, were never issued in final form.

However, over the past few years, except in the area of developmental assessment and the special needs of adolescents, the medical community has reached agreement on the procedures that are most appropriate attitude was that individual clinicians, not the federal government, were in the best position to judge what procedures should be performed on an individual child.

The approach of leaving wide discretion to the states was not successful. Many states did not include in their screening package the recommended procedures. In 1975, a survey of state EPSDT screening packages showed that of the 30 states responding, only 4 provided all the services recommended by HEW.[19]

Among CDF study states, Michigan, South Carolina and New York followed the federal recommendations, with each state adding one or two other tests to its package.[20] But in New Jersey, all laboratory procedures were optional, performed only "if medically indicated." Mississippi tested for tuberculosis only if there was a history of it in the family, even though the AAP's screening *Guide* recommends screening all children for tuberculosis when the prevalence exceeds 1 percent, as it does in parts of Mississippi.[21]

In addition to leaving out recommended procedures from a state's screening package, leaving out procedures that are in the package was also a problem.[22] According to a staff member at a local Medical Assistance Unit in New Jersey,

> That's one of the weak aspects of the program. Once in a while an astute mother calls her social worker who contacts us to report that the doctor didn't do any

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for preventive pediatric care. Among a group of 390 doctors--half clinicians and half academicians--there was 85 percent agreement on the major aspects of screening. (Hugh C. Thompson and Charles E. Osborne, "Development of Criteria for Quality Assurance of Ambulatory Child Health Care," *Medical Care*, Vol. 12 (October 1974), pp. 807-827.

A sample of over 1,300 practicing primary care physicians was in substantial agreement when they were asked to validate these criteria of the experts. (Thompson and Osborne, "Quality Assurance of Ambulatory Child Health Care:Opinions of Practicing Physicians About Proposed Criteria," *Medical Care*, Vol. 14 (January 1976), pp. 22-38.) Similarly, the preventive care procedures recommended by the American Public Health Association, the Association of Schools of Public Health, the Association of Teachers of Preventive Medicine, and the Fogarty International Center were also in substantial agreement. See *Preventive Medicine USA*, Task Force Reports sponsored by the John E. Fogarty International Center for Advanced Study in the Health Sciences, National Institutes of Health, and the American College of Preventive Medicine (New York: PRODIST, 1976)

[19] Survey by the National Health Law Program, as cited in Geraldine Dallek, *Your Role in EPSDT: A Guide for Health Professionals and Community Organizations* (Los Angeles, Calif.: National Health Law Program, undated), p. 19.

[20] Michigan screens adolescents for venereal disease; South Carolina tests for intestinal parasites and adds health counseling; New York also adds counseling, referral to a dentist and whatever other procedures are deemed necessary by the provider.

[21] Frankenburg and North, *A Guide to Screening for the EPSDT Program Under Medicaid*, p. 154.

[22] HEW policy is that providers need not perform all procedures in the package. However, the state has the obligation "to make arrangements for additional procedures where necessary." (*Medical Assistance Manual*, Part 5, 5-70-9.00, Answer to Question 8.)

> blood work. But otherwise, we really have no feedback about whether complete screens are done.

Of CDF's five study sites, only South Carolina and Michigan had systems to check whether screening standards were actually met. In Essex County, New Jersey, where about 90 percent of the children were screened by private physicians, the state had no enforcement mechanism to assure thorough assessments, other than a statement signed by the physician and a bill for screening.

In New York, physicians in private practice signed no written agreements to provide screening. For clinics and hospitals, agreements signed with the local Department of Social Services included a list of screening procedures but did not carry an obligation to perform them. State policy read:

> In negotiating general agreements with providers, it should be emphasized that they are not contractual documents obligating providers to provide services upon demand to clients. Rather, they are statements of intentions representing an understanding between parties of planned responsibilities in the program.[23]

What happened when screening packages were incomplete, defined in inadequate detail and poorly monitored? For many children, important screening procedures were omitted.[24] Only two of our study sites had quantitative information on screening procedures performed. Tables 5 and 6 show certain of the screening tests given to children through EPSDT in Genesee County, Michigan and Florence County, South Carolina. Table 6 shows that in Florence County, for example, an assessment of immunization status was frequently omitted, as were vision and hearing tests. Unfortunately, little more can be concluded from these data because the age groupings the states used, as we discussed earlier, combined groups of children with different health needs and masked whether the right procedures were given to the proper age group of children.

Aside from what can be concluded from referral data, none of our other study sites had data on the extent of screening procedures performed. While no figures were

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[23] Child Health Assurance Program, "Bulletin 190" (New York: Department of Social Services, September 30, 1974), p. 30.

[24] Other studies confirm that important screening procedures were omitted. A sample of EPSDT claims submitted by providers in Vermont revealed that 53 percent of screenings performed by private physicians were not complete for the age of the child. For screenings by public providers, 15 percent were incomplete. (Record search done in conjunction with "EPSDT in Vermont and South Carolina," Field Training Report Submitted in Partial Fulfillment of Requirements for a Master's Degree in Public Health by Elizabeth S. Milliken, July 20 1976, Chapel Hill, North Carolina.) For a discussion of screening practices carried out in pediatric practice outside the EPSDT program, see Kathryne Bernick, "Issues in Pediatric Screening," *Children's Medical Care Needs and Treatment*, Vol. II (Cambridge, Mass.: Ballinger Publishing Company, in press).

Table 5

SCREENING TESTS GIVEN BY AGE GROUP BY NUMBER AND PERCENT OF AGE GROUP SCREENED - GENESEE COUNTY, MICHIGAN

	Children Under Age 6 Tested		Children Over Age 6 Tested		Total Children Tested	
	No.[1]	Percent	No.[1]	Percent	No.[1]	Percent
Height	3,685	100.0	4,781	100.0		
Weight	3,685	100.0	4,781	100.0		
Head Circumference	1,174	31.9	-	0.0		
DDST	3,685	100.0	12	0.3		
Blood Pressure					5,693[2]	67.2
Vision Screen	3,044	82.6	4,781	100.0		
Hearing Screen	3,677	99.8	4,781	100.0		
Hematocrit	3,685	100.0	4,781	100.0		
VDRL					1,956[2]	23.1
GC Culture					1[2]	0.0
Tuberculin					6,457	76.3
Urine-sugar					7,199[2]	85.0
Urine-albumin					7,196[2]	85.0
Sickle Cell	1,766	47.9	2,293	48.0		
Lead Poisoning	3,120	84.7	-	0.0		
Immunizations	3,685	100.0	4,781	100.0		
Physical Health	3,685	100.0	4,781	100.0		
Health History	3,685	100.0	4,781	100.0		

[1] The number of children screened by age group was reconstructed from percentages given in the source documents, and are not exact.

[2] Source data does not permit a breakdown by age for these tests.

Source: "EPSDT Clinic Screening Services Annual Report 1975," Michigan Department of Social Services, Publication 216 (6-75).

Table 6

SCREENING TESTS GIVEN IN FLORENCE COUNTY, SOUTH CAROLINA
BY NUMBER AND PERCENT OF AGE GROUP SCREENED

	Children Under Age 1 Tested		Children Ages 1-5 Tested		Children Ages 6-21 Tested	
	No.	Percent	No.	Percent	No.	Percent
Total Screened	114		183		357	
Physical Examination	114	100.0	183	100.0	357	100.0
Vision	5	4.4	35	19.1	342	95.8
Hearing	5	4.4	46	25.1	342	95.8
Immunizations	52	45.6	77	42.1	220	61.6

Source: Medical Contacts Report, Part I (Services), EPSDT, Florence County, July 1 through December 1975, South Carolina Department of Health and Environmental Control, Child Health Services.

available on vision and hearing screenings in Mississippi, various screening providers acknowledged that they had neither the time nor the capacity to do them. CDF discovered also that state standards for vision and hearing tests often were not met. In Oktibbeha County, a Head Start nurse who observed EPSDT clinics noted that, until the recent acquisition of an audiometer and special vision charts, hearing screening had consisted of whispering to a child, and vision screening had consisted of holding up pictures and asking what they portrayed.[25]

In New York, administrators of Suffolk County's EPSDT program acknowledged that they did not know if the screens performed by the private physicians were complete. But among the four pediatricians whom we interviewed, one did not have audiometric equipment and one did not perform vision screening routinely, even though they saw substantial numbers of Medicaid patients. None did dental assessments or referred children to a dentist. Suffolk County's Health Department's seven satellite clinics, where Medicaid children who did not have a regular doctor were frequently referred for EPSDT, were not equipped to do vision or hearing screening.

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[25] According to Mississippi's standards for screening, an audiometer and an "acceptable chart" are to be used for hearing and vision testing.

The dental referral rates were most revealing of the inadequacy of screens. Most children over the age of 3 need to be referred to a dentist. Yet, nationwide, an average of only 25 percent, or one out of every four screenings, resulted in in a dental referral.[26] Table 7 shows the extremely low dental referral rates in CDF's study states.

Table 7

RATE OF REFERRALS FOR DENTAL PROBLEMS IN CDF STUDY SITES

State	Percent Referred
Michigan	31
Mississippi	61
New York	7
New Jersey	6
South Carolina	49

Source: *EPSDT Statistics*, Fiscal Year 1975. (See Appendix F.)

With the exceptions of Mississippi and South Carolina, these rates are unacceptably low and suggest that dental referrals are all too frequently omitted from the care children receive under EPSDT.

Trained Personnel

The quality of screening is affected not only by the appropriateness of the tests but by the skill of the individuals administering them. A variety of personnel--including nurse practitioners, physicians' assistants, nurses, health aides, and volunteers--can perform or help with screening. In fact, there is much evidence that personnel other than physicians have the capacity to provide routine child health care competently, to the greater satisfaction of patients, and at less cost than physicians.[27] While use of such personnel should be encouraged, substantial training and supervision are required. We found that training and supervision at times were inadequate. As one director of the child health program in a state health agency told us:

> There has not been enough emphasis on the quality of training for clinic staffs. For example, we need more specialized training of nurses on how to do evaluations of the heart and ears. If the program doesn't continue to work on training people to do quality screening, it will die.

And a caseworker in Florence County, South Carolina concurred:

> Sometimes it seems like the nurses are geared to specific, traditional medical problems and are locked in as far as referrals go. For less traditional health problems, a lot more judgment is required and maybe because they're not well enough trained, they don't pursue those.

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[26] *EPSDT Statistics*, Fiscal Years 1975 and 1976. (See Appendix F.)

[27] See *Doctors and Dollars Are Not Enough* (Washington, D.C.: Children's Defense Fund, 1976), pp. 86-89.

In our study states that used health departments as the primary screening providers (Michigan, Mississppi and South Carolina), nurses and technicians provided all the screening services. We found gaps in their training. For example, screening nurses in Michigan must take a two-day course of training, but the nurses were not trained to use stethoscopes and omitted checking the heart during the physical examination. A screening nurse in Genesee County reported that she had received three days of training in preparation for taking the job, but after such brief training she was bewildered when she began. In South Carolina, in many parts of the state, screening nurses received no special training. Many were public health nurses who, according to one observer, had no recent experience in direct patient care prior to performing screening.

"EP": Early and Periodic

> Lucille Rant took the advice of a welfare caseworker who visited her home and suggested she bring her three-month-old baby to the Health Department for a checkup and shots. She was told that her baby was healthy and that she should bring her baby back for the second round of shots. But she wasn't told when to come or how the visit would be arranged and now, about six months later, she is still wondering.

For case-finding and treatment to be effective, they must be performed early in a child's life and at prescribed intervals after that. Congress mandated that screening be early so that problems could be identified before permanent damage was done. The other part of the formula was for screening to be periodic, to assure that children received regular assessments throughout their growth, to keep track of prior ailments and treatments and to discover quickly new problems that developed. Data from the EPSDT program are beginning to provide evidence that periodic assessments and treatment do reduce health problems in children. Children rescreened in Michigan, for example, had 13 percent fewer referrals than children screened for the first time.[28]

According to recommendations by the American Academy of Pediatrics, children should be assessed 14 times between birth and the age of 21--five visits for a health evaluation in a child's first year of life, two in the second, one in the third, and a visit every two or three years subsequently.[29] Some of the

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[28] For further interpretation of the data, see: *EPSDT, Is Early Periodic Screening, Diagnosis and Treatment Achieving Its Goal?* (Michigan: Department of Social Services and Public Health, Publication 216, Rev. 10-76, July 1976).

[29] According to HEW guidelines, states are to set periodicity schedules based on advice from "public health specialists and other medical and dental experts within the state." (*Medical Assistance Manual*, Part 5, 5-70-20(E)(4).)

Table 8

MASTER SCHEDULE FOR SCREENING RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS

TEST OR PROCEDURE	AGE OF CHILD													
	3-7 days	2-6 weeks (1)	4-5 months	6-7 months	8-10 months	11-14 months	16-19 months	22-25 months	3-4 years	5-7 years	8-10 years	11-12 years	13-15 years	16-21 years
Medical and Developmental interview	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Medical Examination	▨	▨	■	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Immunization Review			▨	▨	▨	▨	▨	■	■	▨	■	■	▨	■
Dental Care Review (2)									▨	▨	▨	▨	▨	▨
Vision (by observation and report)	▨	■	■	▨	■	▨	■	▨	■					
Visual Acuity Test									▨	▨	▨	▨	▨	▨
Hearing (by observation and report)	▨	■	■	▨	■	▨	▨	▨	■					
Hearing by audiometry (3)									▨ (3)	▨ (3)	▨	▨	▨	▨
Physical Growth	▨	▨	▨	▨	■	▨	■	▨	▨	▨	▨	▨	▨	▨
Psychomotor development (4) by screening test					▨	■	■	▨	■					
School Progress Review										▨	▨	▨	▨	
Tuberculin Sensitivity (5)					▨	■	■	■	▨	■	■	■	▨	■
Bacteriuria (girls only)									▨	▨				
Anemia	▨	■	■	■	■	▨	■	■	■	■			▨	■
Sickle Cell Diseases	▨	■	■	■	■									
Sickle Cell and Hb C Traits													▨	■
Undue Lead Absorption (6)						▨	▨	▨	▨					

▨ Do at this age; ■ Do at this age unless done previously at scheduled age.

(1) A visit at approximately 2 mos. of age is necessary to begin the normal immunization schedule.
(2) Visual inspection of the mouth and teeth is part of the medical examination at all ages.
(3) Test hearing yearly from age 3 to 6.
(4) Test development earlier and more frequently in known high risk groups.
(5) Test tuberculin less frequently or omit in known low risk groups.
(6) Test only exposed children, test every 6 mos. from age 1 to 3 yrs.

Source: William K. Frankenburg and A. Frederick North, *A Guide to Screening for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) Under Medicaid*, prepared by the American Academy of Pediatrics (Washington, D.C.: Social and Rehabilitation Service U.S. Department of Health, Education, and Welfare, June 1974) pp. 54-55.

screening procedures should be done at each visit, depending on the age of the child. (See Table 8 for the periodicity schedule recommended by the AAP.)

Ideally, the EPSDT program should be reaching children when they are newborn babies. We found that, generally, EPSDT programs did not have a mechanism for identifying newborns early. Generally, program staff did not know about the birth of a baby until families came to the welfare agency for Medicaid recertification--usually at six-month intervals. An exception was Suffolk County's program, where children under one year of age were given top priority. Each hospital providing services to mothers on AFDC or medical assistance reported the birth of new babies to the County Department of Social Services, which then sent the families notices of EPSDT services and encouraged them to seek early care for their children.

Three other kinds of shortcomings in the design of EPSDT programs in our study sites made early and periodic screening of eligible children almost impossible. First, except in New York which adopted a screening schedule comparable to the one recommended by the AAP, our study states adopted inadequate, often rigid schedules. New Jersey and Mississippi planned to screen all children once each year. If these schedules were followed, very young children would be scheduled for too few screenings; older children would be recalled for screening more often than was necessary. Michigan's and South Carolina's schedule called for screening young children more often than older children, but not frequently enough to assure that they received all needed immunizations or that their development could be monitored as carefully as it should have been.[30]

Second, only Michigan's program had the administrative system to identify, reach promptly and rescreen children whose next turn had come.[31] And third, the large number of families who lost eligibility for Medicaid each year meant that many children were not eligible when their turn for screening came up again. Some even lost eligibility before receiving their initial screen. As a result of the eligibility requirements for EPSDT discussed earlier, approximately 30 percent of children eligible for Medicaid were no longer eligible one year later.[32] Assuming policies like the ones in CDF study states--that children are to be screened once within the year following Medicaid certification--15 percent of newly eligible children (or about 3.5 percent of all eligible children) would lose eligibility before their first screening. Assuming children were rescreened sometime during the second year following the first screening, about 40.5 percent would not be eligible when their second screening was due. The total loss of children due to eligibility turnover would mean that about 34.7 percent of all children eligible during a year would fail to receive their first or second screening.[33]

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[30] According to Michigan's schedule, children should be screened at age 6 months, at ages 1, 3, and 5, and once every three years thereafter. South Carolina allows for children to be screened near birth, once during the period of age 4 to 12 months, at age 3, and every three years thereafter.

[31] To our knowledge, HEW has never issued guidelines on this important aspect of the EPSDT program.

A caseworker in Flint, Michigan commented:

> Children do not remain on Medicaid long enough to be eligible when their rescreen comes due. I don't have *any* cases I've had that long--that is, for two years if the child is under 5, or for three years if the child is over 5.

In our study sites, administrators could only estimate the magnitude of turnover in Medicaid eligibility. Suffolk County Medicaid administrators told us that their program experienced a turnover rate of approximately 50 percent annually; about 40,000 children were eligible at any one time, but probably about 60,000 were eligible at some point in the year. A South Carolina official estimated that 40 to 50 percent of the children who were screened once could not be rescreened because they had lost their eligibility. The annual turnover rate among New Jersey eligibles was 25 percent. Mississippi could not provide comparable data, but an

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[32] This is approximately the rate of turnover for AFDC families, according to the most recent study of AFDC. The study found that about one in four families receiving AFDC lost their eligibility during the course of a year. (National Center for Social Statistics, *Findings of the 1973 AFDC Study, Part IV, Discontinuance of AFDC Money Payments During 1973* (Washington, D.C.: Social and Rehabilitation Service, HEW, January 1975), Publ. No. (SRS) 74-03767, NCSS Report AFDC-4 (73), p. 2.)

We have adjusted that figure upward slightly to 30 percent because a disproportionate number of new entrants in the AFDC program have children due for screening or other EPSDT services, and studies show that turnover is highest among new entrants in the AFDC program. A family who has been on AFDC less than a year is twice as likely to lose eligibility as a family whose case has been open two or more years. Families whose children require screening contain disproportionately large numbers of new entrants in AFDC because:

- families who have just been certified for AFDC are routinely informed about EPSDT and their children are most likely to be referred for screening;
- screenings are most frequent among young children, and the group of young children contains disproprotionate numbers of children whose birth carried the family onto AFDC in the first place.

[33] On the other hand, if children were informed and screened within 60 days after becoming eligible, fewer than 1 percent of all children would lose eligibility before their initial screening, even with a 30 percent eligibility turnover rate.

Oktibbeha County caseworker noted that some children never received their initial screening because they lost eligibility so quickly. The same was true in Genesee County, Michigan, which experienced a turnover rate of about 4 percent monthly.

Using the Full Range of Screening Resources

Despite explicit federal requirements that states make maximum use of existing resources for screening, many have not done so, and HEW has not enforced these mandates vigorously.[34] Excluding qualified providers has had several consequences. First, in states which used primarily local health departments for screening, children who already had a doctor had to be screened elsewhere. Some parents in these states did not want to switch providers and so did not take children to the health department for screening. But for those who did, children may have gotten screened at the expense of further fragmenting the health care they received. Second, limiting the screening providers denied children their right to receive services from the participating provider of their choice.[35] In places where the certified provider was not known or trusted by recipients, parents simply did not use screening services. Third, when states restricted the use of available screening providers, families had to wait longer for appointments than they would have otherwise, and instead of being able to go to a provider conveniently located, children and families often had to go across town or across the county for screening. Similarly, states' failure to reimburse through Medicaid for the services of non-physician personnel capable of screening children, such as nurses, nurse practitioners and aides, further restricted the ease with which children could get screening services.

But even in states which permitted a variety of providers to do EPSDT screening, a high proportion chose not to. Most often, the reasons were related to Medicaid in general and not to screening in particular. (In Chapter 5 we will discuss those concerns not exclusive to screening.) But the issue of low reimbursement levels for screening did have two consequences. In the first place, low reimbursement levels for screening discouraged providers from participating in EPSDT, aggravating the problems we have discussed about limited providers. Secondly, if screening rates were low relative to rates for other Medicaid services, providers did not bill their services as "screening," but as "office visit" or

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[34] For a more elaborated discussion of the topic of making maximum use of providers, see Chapter 7.

[35] 42 U.S.C. §1396a(a)(23); 45 C.F.R. §249.20.

"check up" which had higher reimbursement rates. The result was that the state Medicaid agency had no way to know which children were screened--information it needed to make sure needy children were screened and that, once screened, they got follow-up care.[36]

Should Schools and Child Care Centers Provide Screening?

Many have advocated that schools, Head Start programs and other child care centers should screen children in EPSDT. These institutions are among those which federal guidelines recommend to provide screening services.[37] But involving them in EPSDT presents a unique set of issues and problems.

Schools and child care centers have one characteristic that argues strongly in favor of their participation in EPSDT: they reach a high proportion of children; children are a "captive" population. Problems of outreach, transportation, broken appointments and follow up are often simplified or nonexistent. Screening is a simple matter of calling the child out of class; follow-up is probably easier because the responsible adult can be contacted directly through the child; and the child's condition can be observed over time. Moreover, some schools and child care centers have close contact with and access to families and are therefore able to involve parents in the process of screening and follow-up care. Additionally, some have a foundation of preventive health services upon which an EPSDT screening service might be built.

There are drawbacks to their use as well. There is wide variation among schools and child care centers in the quality and comprehensiveness of health services they offer. Many offer services far more limited in scope (often only periodic vision and hearing testing and immunizations) and quality (due to inadequate numbers of health personnel and facilities) than required for EPSDT screening.[38] Screening in schools, especially, generates problems of confidentiality: information obtained about children during screening is accessible to a wide range of people beyond health professionals. It may be released or used inappropriately by school personnel to label and to make decisions about children's placement in school programs.

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[36] This problem also results when states fail to use in EPSDT all providers who perform assessments.

[37] *Medical Assistance Manual*, Part 5, 5-70-20(B)(7).

[38] There have been several obstacles to assuring uniform quality in school health programs statewide. First, although state education agencies have or could establish the authority to set uniform standards, typically their monitoring and compliance of school district activities has been inadequate. In addition, it can be cumbersome for the state education agency to negotiate with schools for the provision of school health services. Suffolk County, for example, contains 74 autonomous local school districts; separate arrangements would have to be negotiated with each one for its cooperation in EPSDT.

Furthermore, it is usually impossible to provide comprehensive care in such institutions. Children screened in schools or child care centers must go elsewhere for diagnosis and treatment, inevitably resulting in further fragmentation of children's health care. Finally, it is difficult for schools and child care centers to screen eligible children without singling them out and stigmatizing them as welfare recipients.[39]

In our study sites, we looked at health programs in schools and child care centers to determine the extent to which they were participating or might usefully participate in EPSDT screening. At the time of our visit, no schools or child care centers provided EPSDT screening. Ironically, schools in areas where health resources were scarce, and where schools could agument the reach of EPSDT, offered few health services.[40] Where health resources were more ample, school health services, too, were more developed and had greater potential to provide complete screening, although the need for them to do so was less. While no programs were providing screening, we found some child care centers, Head Start programs in particular, in areas where screening resources were scarce that could, with technical assistance, become qualified to do quality screening, referral and follow-up.

Most of the issues we have raised and the findings from our study sites argue against relying on schools

[39] HEW offers policy advice for avoiding this problem. "The school can, for example, send the names of all children screened to the state agency. From such a list, the state could determine the names of eligible recipients and begin its follow-up procedure." See *Medical Assistance Manual*, Part 5, 5-70-9.00, Answer to Question 17.

[40] School health services in Oktibbeha and Florence counties were limited primarily to hearing and vision testing. In Oktibbeha County, the school system serving the city schools employed a nurse with funds from Title I of the Elementary and Secondary Education Act, who worked with children eligible for Title I services and their families. The school system serving the outlying areas of the county also employed a nurse using Title I funds and, with volunteer help, she accomplished annual vision and hearing screening of all elementary school children. Older children received no school health services.

In Florence County, the school system employed nurses who carried out vision and hearing screening and notified parents of health problems they or other school personnel observed. Aside from occasional communication between the Title I nurses and EPSDT screening nurses, there was no relationship between the school health activities and EPSDT in these counties.

and child care centers for screening. However, in some instances, schools and child care centers have or can overcome the problems discussed and should be used in EPSDT.[41] For instance, where there are not sufficient resources for all Medicaid children to have a regular source of comprehensive health care, child care centers or schools with adequate staff, space and equipment could provide screening. There would have to be careful assurances that they refer children for needed care and that they follow up to make sure children receive services. In addition, the child's status as a Medicaid recipient must remain confidential, and there must be strict policies governing access to health history information by staff in and outside the school or child care center.

Is Duplication of Services a Problem?

Theoretically, EPSDT can duplicate other preventive services an eligible child receives. For children who have regular doctors, or those who get immunized at the health department, or those whose schools test vision and hearing, EPSDT screening may cover the same ground.

We believe, however, that the amount of duplication that actually takes place is small, not enough to constitute a problem, nor worth the expense of trying to eliminate it. First, the number of conditions detected in screening that were previously undetected and untreated was high--indicating that these children were not receiving quality primary care already.

Second, since small percentages of children eligible for EPSDT

[41] Chapters 5 and 7 discuss policies which are barriers to the participation of child care centers and schools as screening providers. In order for schools and child care centers to become screening providers, policy clarification is needed on another policy as well. It must be clear whether programs funded by state or federal funds other than Medicaid, but which provide services to Medicaid children, should be reimbursed for these services by Medicaid as the "first dollar"--that is, if other sources of funds are available to a provider, who should pay for services to Medicaid children?

This issue is especially important because of a Medicaid policy stating that Medicaid will not pay for services that are free to everyone in the community. (*Medical Assistance Manual*, Part 5, 5-40-20; see also, *Medical Assistance Manual*, Part 5, 5-100-00 and the "Handbook of Public Assistance Administration," (Supp. D), Section 6341.) Several administrators told CDF staff they interpreted the policy to mean that schools, for example, cannot receive Medicaid reimbursement for screening services provided to Medicaid children in the school. However, if agencies and organizations are required to look to third party payors as a source of funds, the problem is eliminated, since government agencies, including Title XIX agencies, are considered to be third parties and services are no longer considered "free." (*Medical Assistance Manual*, Part 5, 5-40-20.)

For further discussion of the issues related to Medicaid reimbursement for school-based programs, see B. A. Myers, "Medicaid Reimbursement for School-Based Primary Health Care Issues and Strategies, Memorandum prepared for the Robert Wood Johnson Foundation, 15 September 1976.

screening actually received it, and even smaller percentages received the services at appropriate periodic intervals, the potential for duplication was small. While a school vision or hearing test, for instance, might duplicate parts of an EPSDT screen one year, it would not duplicate it the next, because the child is likely to have lost EPSDT eligibility. And school health services often miss numbers of children who are absent the day of the screening or who transfer between schools and miss the school physical. EPSDT screening gives these children their only other chance to be screened.

And third, screens performed by physicians, schools and EPSDT providers are often incomplete, further reducing the likelihood of duplication.

A Special Challenge: Adolescents

> We're having a big problem with adolescents. They just say "no." Maybe they think they're too old to be needing checkups or maybe we're not doing the right things for them. Maybe they're afraid they may be pregnant or that someone will discover drugs or V.D.

As this statement to us by a caseworker in Florence County illustrates, the health problems of adolescents are decidedly different from those of young children. Tailoring health services to the special needs of adolescents has been enormously difficult for nearly every health program in this country. Our analysis of federal and state policies and of local practices in EPSDT programs has shown that standards or services suited to the particular needs of adolescents have not been developed. Nor have programs experimented with approaches that might be effective in meeting the needs of adolescents through EPSDT.

Federal guidance about screening has been silent on proper assessment procedures for adolescents. While the screening procedures recommended in the guidelines were not specific to age, they were clearly geared toward young children.[42] For example, guidelines calling for an "unclothed physical inspection" never mentioned that this might include a pelvic examination for young women. HEW guidelines make no mention of procedures for identifying or meeting family planning needs of EPSDT recipients. Tests for venereal disease or for pregnancy are mentioned following the recommended screening procedures, as two of many tests that should be considered.[43]

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[42] It should be noted that an HEW policy decision, issued at the same time as the screening guidelines, allowed states to "phase in" all eligible individuals under age 21 by starting with children under 6 years of age. Clearly, the emphasis in the program in June 1972, reflected in the screening guidelines, was young children. (See *Medical Assistance Manual*, Part 5, 5-70-20(E) and (B)(5).)

For approximately four years now, HEW has been working to develop EPSDT standards for adolescents. To date, however, no policy statements have been released and no official guidance has been given to state or local EPSDT programs.

Policies and practices in our study sites reflected the lack of federal leadership and assistance in this area. Although a number of professionals in our study sites discussed the problem of providing quality care to adolescents, none of them had developed services suited to that group.[44]

Several people we interviewed pointed out that just as screening procedures must take into account the special needs of adolescents, so must certain administrative arrangements. Most often mentioned was the issue of assuring an adolescent that personal health history information would remain confidential. As one child care worker in Newark, New Jersey, said,

> Adolescents here know that any health service they get from Medicaid is going to show up on a bill which their whole family sees. They don't have the option of being checked for V.D. or pregnancy without the parents knowing. So, of course, they don't want the service.

People in other places told us, too, that the practice of sending families an itemization of each of the Medicaid services family members received was a great deterrent for adolescents to use EPSDT or other Medicaid services.

Recommendations

1. The requirement in Title XIX to screen for "physical and mental defects" should be replaced by a requirement that states assure regular comprehensive health assessments for children eligible for Medicaid.

2. HEW should issue regulations immediately defining standards for what is an acceptable assessment. Standards should be established in consultation with health professionals

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[43] "In addition to the basic screening procedures described in Section (E)(7) above, there are several other screening tests that should be considered. Their appropriateness will be determined by the individual's age, sex, health history, clinical symptoms and exposure to disease. Among the procedures that could be included in the screening process are a cardiac scan (if not done in the course of physical inspection), chest x-ray, blood pressure, pinworm slide, urine culture (for girls), serological tests, drug dependency screening, and stool specimen for parasites, ova and blood. When it is required for admission to schools, a child should have a smallpox vaccination." (*Medical Assistance Manual*, Part 5, 5-70-20(E)(8).)

[44] Information from the EPSDT program is beginning to suggest the kinds of special arrangements which might be appropriate for adolescents. For example, a survey conducted in Michigan found teenagers most frequently object to the physical assessment--particularly the males who "are uncomfortable with clothes-off physical examination by a nurse." (*EPSDT, Is Early Periodic Screening, Diagnosis and Treatment Achieving Its Goal?* (Michigan: Departments of Social Services and Public Health, Publication 216, Rev. 10-76, July 1976), p. 4.)

and consumer groups. At a minimum, they should include the full array of assessment procedures recommended in EPSDT guidelines, plus counseling and the changes in the area of developmental assessment that we recommend in Chapter 6. Automatic referral to a dentist (for children not already under regular dental care) and provision of immunization as needed at the time of screening should be added. Vision and hearing testing appropriate to the child's age should be defined and required. The regulations should also establish standards for the frequency with which children of various ages should be assessed and the procedures necessary at each visit. The schedule should be based on the American Academy of Pediatric's "Master Schedule for Screening."

States should be required to carry out the federally prescribed set of procedures according to the schedule, except in circumstances where, on the basis of evidence by the state that particular procedures are not needed, HEW issues a waiver in writing.

3. *Screening should not be required before a child can get needed routine dental care*. Federal regulations should make explicit that any child can receive dental care regardless of whether referred by a provider of an assessment.

4. *State and local medical and pediatric societies should take the lead in educating providers about needed assessment procedures and the importance of adhering to the agreed upon standards*.

5. *Federal regulations must require states to have a mechanism to ensure that all children assessed through EPSDT have received the full array of needed assessment procedures*. States could fulfill this requirement, for example, by having providers use a check-off form, itemizing what procedures are performed during an assessment. Based on these, the state agency could develop profiles and begin working with providers to change assessment practices if indicated. In addition, state agencies should institute a mechanism through which parents and advocates can report complaints about the adequacy of assessments and through which states look into such complaints.

6. *Federal EPSDT reporting requirements should be revised to include additional information on types of conditions which need follow-up care, for children in the age groupings of 0-3, 4-6, 7-12 and 13-21*. This information is a prerequisite for assuring that follow-up care is received and for judging the adequacy of health resources to deal with the various problems children have. The following categories should be added: iron deficiency anemia, disorders of the skin, motor difficulties, parasites, incomplete immunization, genito-urinary problems, digestive-gastrointestinal problems, muscular-skeletal abnormalities, height-

weight, problems related to heart or circulatory system, orthopedic conditions and acute infections.

7. *Efforts should be made to move toward defining norms against which state and local EPSDT statistics can be compared*. HEW should compile from the National Health Examination Survey and other sources all existing data on the prevalence of various health problems in poor children. On the basis of monthly EPSDT statistics, HEW and state administrators, with the help of representatives from state and local medical and pediatric societies, should begin exploring any extreme variations from expected norms in the prevalence of conditions found in localities. To help correct possible problems in reporting or to improve the quality of assessments, state administrators and representatives from medical and pediatric societies should look into the reasons behind significant deviations.

8. *State and county EPSDT administrators should design programs so that parents of young children can be present during the assessment*. To the greatest extent possible, children's appointments should be scheduled at times when a parent can be present. For parents who would otherwise be unable to attend, it should be possible for their children to be assessed during the evenings or weekends. Efforts should be made to have the space and time to allow individual counseling and talks with parents at the time of the assessment.

9. *HEW should issue immediately a checklist of all of the information that should be elicited by providers in taking a health history.* Using this as a model, state and county administrators, along with members of the medical and pediatric societies, should encourage providers to develop appropriate health history forms.

10. *HEW should convene immediately an advisory panel to establish appropriate assessment procedures for adolescents as well as policy guidance to states and counties for reaching adolescents with EPSDT services*. EPSDT might be more successful in reaching adolescents if services were offered with other services that adolescents use (e.g., pre-employment physical examinations, sex education or information about family planning). In addition, special adolescent clinics, set up evenings and weekends at places where adolescents spend time (e.g., shopping centers and recreation centers) might be more effective. Further, adolescents should be trained and employed to conduct outreach, and to assist with assessments and counseling.

11. *HEW should immediately begin work with state health officials to upgrade the quality of training given to nurses, paraprofessionals and others who perform parts of an assessment*. HEW should help states develop training programs and pro-

vide them with training materials. The EPSDT portion of Medicaid plans should include descriptions of the initial training and continuing education for personnel who assess children. The adequacy of training should be reviewed on an annual basis by state and federal officials.

12. HEW should assist state and county EPSDT administrators to work out arrangements with hospital staff so that newborns can be assessed and put in touch with a regular provider. HEW should also help administrators to build into data and reporting systems a mechanism for identifying and informing children when it is time for a follow-up assessment.

13. Child care centers and schools should assume the role of identifying children who need EPSDT, referring them to the program and checking to assure that they have received all needed services. These checks can be performed by school personnel when children and parents are interviewed for entry into elementary and junior high school or when children routinely see a school doctor or nurse.

Where schools or child care centers (1) are in places with scarce medical resources, (2) can reach children and follow their problems more effectively than other providers, or (3) show capacity to provide assessments and follow up, they should be allowed to provide EPSDT services to children.

HEW should remove policy barriers to using qualified child care centers or schools in the program, and provide assistance to them in meeting licensing and certification standards and working out agreeable terms with state or local Medicaid agencies.

14. States should make necessary agreements with other programs so that EPSDT assessments can fulfill health entrance requirements in other programs (e.g., Head Start, Title XX, schools).

Chapter 5

After Screening — What? Diagnosis and Treatment in EPSDT

> A screening program that does not result in adequate treatment of health problems has failed its purpose.[1]
>
> When a provider takes the initiative in discovering health problems in persons without complaints, as in screening, the provider should be certain that discovery of such problems will do more good than harm.[2]

EPSDT's primary purpose was to intervene early in the lives of children who had potentially crippling health problems, to save them years of suffering and to save society billions of dollars in remedial services. Screening was only the first step. The key to the program's success was the provision of needed care to these children. To this end, the statute establishing EPSDT stated that, after screening, a child should get "such health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary."[3]

Have children screened received the diagnosis and treatment they need? CDF found large numbers have not.[4]

What the Data Show

As with other aspects of EPSDT, national data did not report how many *children* needed and received follow-up diagnosis and treatment. But we can estimate the number who needed further care from the number of conditions referred following screening. In fiscal 1975, there were 72.7 conditions referred per 100 screenings and in fiscal 1976, there were 69.2 conditions referred per 100 screenings.[5] For our study sites, the number of conditions referred for fiscal 1975 are shown in Table 1. Note that the national figures were between those for Essex County and Genesee County.

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[1] Victor Eisner, "What Happens After Screening," in A. Oglesby and H. Sterling (eds.), *Proceedings of the Biregional Institute on Earlier Recognition of Handicapping Conditions in Childhood* (Berkeley, Calif.: University of California School of Public Health, 1971), pp. 52-56.

[2] William K. Frankenburg and A. Frederick North, *A Guide to Screening for the EPSDT Program Under Medicaid*, prepared by the American Academy of Pediatrics for the Social and Rehabilitation Service (Washington, D.C.: HEW, June 1974), pp. 3 and 5.

[3] 42 U.S.C. §1396d(a)(4)(B).

[4] This chapter focuses on follow-up care for children who have been screened. However, millions of children have not been screened and thus have never gotten the follow-up care which screening would have indicated they needed. The numbers here, then, underestimate the total number of children who need follow-up care.

Table 1

CONDITIONS REFERRED PER 100 SCREENINGS IN FISCAL 1975 IN CDF STUDY SITES[1]

County	Conditions Per 100 Screenings
Genesee County, Michigan	89.4
Oktibbeha County, Mississippi	152.8
Essex County, New Jersey	55.1
Florence County, South Carolina	22.1

[1] Suffolk County is not included in this table because its data are clearly inadequate for unduplicated counts.

Source: See Appendix K.

If we look at how many conditions were referred per 100 children referred, we find for our study sites the range shown in Table 2. If we assume that the national numbers again fall between Essex and Genesee counties, we can estimate that the percent of children screened who had at least one condition referred was between 45.7 and 58.9 percent.[6]

Since we were not able to verify these numbers, we estimated the number of children referred for follow-up care using another method, and we came up with a surprisingly similar figure. National data showed that in fiscal 1975, 34.3 percent of all screenings resulted in at least one condition being referred (either vision, auditory, dental or lead paint poisoning). The data also showed that 35.2 percent of referrals were in another category for unspecified conditions.[7] If even half of these unspecified conditions were for individual children not included in the first four categories, then the two percentages (34.3 for one of four conditions and 17.6 for half of the unspecified conditions) added together produced a total of 51.9 percent of screenings which resulted in at least one condition being referred. This

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[5] For the national data on conditions referred, see Appendix F, Table 1.

[6] These figures were derived by dividing the fiscal 1975 national estimate of 72.7 conditions referred per 100 screenings first by the number of conditions (149.1) per 100 children referred in Essex County (resulting in 45.7 percent) and, second, by the number of conditions (115.8) per 100 children referred in Genesee County (resulting in 58.9 percent).

[7] National referral data can be found in Table 1 in Appendix F.

Table 2

CONDITIONS REFERRED PER 100 CHILDREN REFERRED IN FISCAL 1975 IN CDF STUDY SITES[1]

County	Number of Conditions Referred	Number of Children Referred	Percent of Children Referred	Conditions Per 100 Children Referred
Genesee County, Michigan	7,569	5,076	60.0	149.1
Oktibbeha County, Mississippi	1,549	958	94.5	161.7
Essex County, New Jersey	2,251	1,944	47.6	115.8
Florence County, South Carolina	148	126	18.8	117.5

[1] Suffolk County is not included in this Table because its data clearly are inadequate for unduplicated counts.

Source: See Appendix K.

national percentage is very close to the range of 45.6 to 58.9 percent derived from our county data. In this report, we have used a rough range of 45 to 50 percent of children screened who need follow-up diagnosis and/or treatment, although the actual rate varied greatly from place to place.

How many of these 45 to 50 percent of referred children received the follow-up care screening indicated they needed? Unfortunately, what happens to a child after referral is the least well-documented step in EPSDT. There are no regular annual reports required by HEW on the disposition of referred children, and audits of state programs and other special studies have singled out this lack of information as a central weakness of EPSDT programs. A number of different studies have found that fewer than 40 percent of conditions referred received any recorded treatment.[8] For some conditions like hearing deficits, treatment rates were as low as 1 out of every 10 cases referred. These figures if anything were generous since they included such entries as "loss of eligibility" and "parental refusals" as resolved cases.

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[8] See, for example, the following: Harold D. Dickson, et al., *Second Evaluation Re-*

The most recent national study of treatment in EPSDT found that 78 percent of referred children had their cases resolved.[9] But this study and the above percentage were riddled with methodological inadequacies that inflated the number of cases found resolved.[10] A more

port of the EPSDT Demonstration Projects, Covering Cumulative Period April 1974 - September 1975 (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center (second draft), March 11, 1975); Harold D. Dickson, *Suggestions for a Case Management System in the New Mexico EPSDT Program* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, June 1975); Memorandum from Kenneth C. Schneider, Chairman, EPSDT Task Force, Region VI to Regional Health Administrator, *Evaluation of EPSDT in Oklahoma, July - September 1974* (Dallas, Texas: Public Health Service, HEW, Region VI, February 5,1975); *Report on Audit of Early and Periodic Screening, Diagnosis and Treatment Program, Title XIX, Administered by Missouri Department of Social Services, Division of Family Services for the Period Ended March 31, 1974* (Kansas City, Mo.: HEW Audit Agency, Region VII, December 11,1974); *Report on Audit of Early and Periodic Screening, Diagnosis and Treatment Program - Title XIX, Administered by Nebraska Department of Public Welfare, Division of Medical Services for the Period Ended March 31, 1975* (Kansas City, Mo.: HEW Audit Agency, Region VII (Audit Control No. 07-60202), July 10,1975); *Report on Review of Implementation of Early and Periodic Screening, Diagnosis and Treatment Program - Title XIX, Administered by Kansas Department of Social and Rehabilitation Services, Division of Medical Services* (Kansas City, Mo.: HEW Audit Agency, Region VII (Audit Control No. 07-60201), October 20,1975); *Report on the Audit of the Administration of the Early and Periodic Screening, Diagnosis and Treatment Program, Title XIX, by the Medical Services Administration of the State of Alabama Department of Public Welfare, for the Period October 1, 1971 through March 31, 1975* (HEW Audit Agency, Region IV (Audit Control No. 04-60203),August 11, 1975); *Report on the Audit of the Administration of the Early and Periodic Screening, Diagnosis and Treatment Program, Title XIX, by the Divisions of Social Services and Health Services of the State of North Carolina, Department of Human Resources for the Period July 1, 1973 through March 31, 1975* (HEW Audit Agency, Region IV (Audit Control No. 04-60201), undated); and *Report on Review of Regional Management of the Early and Periodic Screening, Diagnosis and Treatment Program* (Dallas, Texas: Social and Rehabilitation Service, HEW Audit Agency, Region VI (Audit Control No. 06-60202), September 29,1975).

[9] Harold D. Dickson and Arthur E. Britt, *EPSDT: Review of Shows for Treatment: A Nine-State Survey (October 1976 - March 1977)* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, March 31, 1977).

[10] The study was a clustered random sample of 3,240 screened children in 47 sites in nine states. However, the sites were selected from lists nominated by the directors of EPSDT programs in the nine survey states, and the sampling of children from each site was from lists of children prepared by local directors. It is not unlikely that poorly performing sites and "lost children" were excluded from the sample. From each site in one state, the sample was trimmed to exclude all but 40 of the dental referrals (one of the least well-treated conditions EPSDT detects). However, the study did not attempt to rely solely on the documentation maintained within the EPSDT program itself, but instead called the parents of referred children whose treatment (if any) was unrecorded; these parents were asked if they had refused treatment or if the referred condition had spontaneously disappeared in the absence of treatment. In addition, the study counted as treated those children whose parents had been unable to wait through a delayed scheduling

accurate conclusion based on the figures from the study is that about 64.5 percent of the referred conditions were diagnosed and/or treated.[11] This is equivalent to 147.6 conditions per 100 children referred, in quite good agreement with the data from our study sites. (See Table 3.)

We have used in this report the figure of 60 percent of referred conditions treated--somewhat lower than the adjusted figure found in the most recent study but higher than those found by other studies and the averages in our study sites. Thus, of the approximately 1.1 million conditions referred for follow-up care in 1976, about .6 million conditions were treated, while about half a million conditions received no follow-up care.[12] Individual EPSDT programs varied extraordinarily, however, as Table 3 shows.

Beyond the question of whether children receive any follow-up care for conditions found in screening is the extremely important question of whether the care received is of high quality. The issue of quality is extraordinarily complicated. The only study addressing it in EPSDT found it to be extremely low. Care was judged to be adequate about 35 percent of the time.[13]

Why were so few children diagnosed and treated for the conditions screening uncovered? There were many reasons. First, the rapid turnover in Medicaid eligibility meant that some children lost their eligibility for EPSDT either in between screening and diagnosis, diagnosis and treatment or before treatment was completed. Second, due to state policies limiting the treatment services states will pay for, certain needed services were not covered under the program. Third, state policies and practices often meant that families had to go to two or more different providers at different times in different places

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of EPSDT treatment appointments and instead had secured treatment at their own expense or through non-EPSDT programs. Finally, the study's calculations allowed a full year for treatment to have been delivered rather than counting only that treatment delivered within the statutory 60-day period for receipt of service.

By making a number of adjustments in the data (for example, by counting as treated those who received services for only one condition despite a referral for multiple conditions, or by counting as treated any child for whom *any* further contact had been made even if the child was thereafter lost before a needed subsequent visit), the report concluded that a high percent of children referred had their cases disposed of.

[11] This figure is derived from study data after accounting for certain methodological errors. The study showed only 3,088 of the 4,782 referred conditions as having received treatment up to a full year after screenings--a rate of about 64.5 percent of referred conditions treated.

[12] For further information on the conditions referred in fiscal year 1976, see Appendix F.

[13] See, Rubin Meyer, M.D. (Project Director), *Tracer Evaluation of Diagnosis and Treatment of EPSDT Referrals* (Ann Arbor, Mich.: University of Michigan, School of Public Health, December 1976), p. 13.

Table 3

TREATMENT RECEIVED THROUGH EPSDT IN CDF STUDY SITES

County	Number Diagnosed or Treated as Percent of Number Referred	Percent Referred Conditions Which Were Resolved (Records Search)[2]	Special Studies
Genesee County, Michigan	-	50 (90 records reviewed statewide)	Genesee County Survey 81%[3]
Oktibbeha County, Mississippi	-	46 (45 records reviewed)	Mississippi Statewide[4] - dental -- 39% - glasses -- 71% - hearing -- 10%
Essex County, New Jersey	-	84 (100 records reviewed)	-
Suffolk County, New York	-	(Survey not conducted)	-
Florence County, South Carolina	88.1[1]	39 (95 records reviewed)	EPSDT/Immunization Survey[5]: - state -- 20% - county -- 10% Florence County % referrals treated 1975[6] -- 423/840 = 50%

[1] Figures reported on Penalty Assessment Report for First Quarter, Fiscal Year 1976. This figure represents diagnosis or treatment provided in the course of a year and therefore over estimates considerably the proportion of problems for which follow-up care was received within 60 days of screening.

[2] Records Search conducted by HEW Regional Office staff as part of Penalty Assessment Report, for quarter ending September 30, 1975, in five or six sites within state.

[3] "EPSDT Patient Screening Results: January 1, 1974 - April 30, 1974," Special Study conducted by the Genesee County Health Department.

[4] *Mississippi - Medicaid Commission, Sixth Annual Report, 1975*, p. 32 and "Medicaid Screening Findings, Annual Report, FY '74-'75," provided by Mississippi State Health Agency.

[5] *The EPSDT Program: An Analysis of Patient Immunization*, Division of Epidemiology - South Carolina Department of Health and Environmental Control, December 4, 1975, and data from that study particular to Florence County (provided to CDF by Gary R. West, Public Health Advisor, Division of Epidemiology, South Carolina Department of Health and Environmental Control.)

[6] Data for January-December 1975, compiled by staff of Florence County Department of Social Services, and provided to CDF by Dr. Harvey Block, Bokonon Systems, Inc. The actual percent of referrals completed would be slightly higher because the treatment provided in November and December 1975 had not been reported as of the end of December when the data were reported to CDF.

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before children were treated. As a result, families got discouraged and children got lost in the shuffle. Fourth, follow-up to screening referrals was inadequate. Fifth, diagnosis and treatment services were not available in many places, either because they did not exist at all or because many providers chose not to participate in Medicaid.

The Consequences of Off and On Eligibility

> Since my involvement in this project, I've become very concerned...when an individual becomes ineligible for Medicaid and medical services are discontinued. The state urges the provider to continue care, but of course this never happens since there are no funds to pay for the services. Referrals to other resources are haphazard and seem to depend greatly on the individual energy, time and commitment of the EPSDT agency staff member. The destructive situation created by such a policy defeats the whole philosophy of the EPSDT program.
>
> Turnover in eligibility of Medicaid recipients is the biggest problem with EPSDT. People become ineligible as many as three times per year. How are we supposed to give them treatment?

These statements by an observer of EPSDT in Maine and by the EPSDT coordinator in South Carolina summed up the experience in all of our study sites and the nation in general. Although EPSDT law requires that needed diagnostic and treatment services be begun "normally within 60 days of screening," because of the high and rapid turnover rate for Medicaid eligibility, even 60 days sometimes was not prompt enough to assure that needed care got to a child before loss of eligibility.[14] The problem was particularly acute for those children needing treatment for chronic conditions. Loss of eligibility meant treatment begun was not completed.

Partly in response to the problem of on and off eligibility, Congress added a provision to Medicaid law requiring states to extend Medicaid eligibility for four months to persons whose families lost AFDC eligibility because of increased hours of or increased income from employment.[15] While State Medicaid plans generally have been changed to comply with this requirement, several state officials questioned whether it was carried out in practice. Michigan officials told us families could get an extension of eligibility for one month; in Mississippi, we were told three months. Officials in South Carolina claimed that eligibility was not extended but that local welfare caseworkers were notified one month before the family was scheduled to lose benefits so that special efforts could be made to help the family obtain treatment before that time.

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[14] 45 C.F.R. §205.146(c)(iii)(B).

[15] This provision became effective January 1, 1974. 42 U.S.C. §1396a(e) and 45 C.F.R. §248.10(b)(4).

But a brief extension of eligibility did not solve the problems of treatment not being provided or of treatment being discontinued in midstream. The extension did not apply to Medicaid eligible children who were not on AFDC. In addition, it did not help children being treated for chronic conditions or for problems requiring treatment over a longer period of time (such as for dental problems or speech or motor coordination). And it did not help in places where scarce treatment resources kept children waiting more than four months before they could begin treatment.

We also found that regaining lost eligibility interfered with effective treatment. In South Carolina, for example, children who regained Medicaid eligibility were given an identification number different from their original one. This made it considerably more complicated to know which services children had already received and which might be needed in the future.

Too Few Services Are "Covered"

Although the intent of the EPSDT amendment to Medicaid was to assure treatment of *all* potentially crippling conditions uncovered in screening, because of the additional costs involved, states strongly resisted the expansion of required services in their Medicaid programs. While the Congress required states to provide all diagnostic services, it gave HEW discretion to define which treatment services must be "covered," i.e., paid for.[16] Under pressure from the states, HEW took a middle ground: in addition to services already covered in their Medicaid plan, states had to provide:

> eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health....[17]

States retained responsibility, by law, to "arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment"[18] if they chose not to cover certain treatment services.

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[16] 42 U.S.C. §1396d(a)(4)(B).

[17] 45 C.F.R. §249.10(a)(3)(iv). It should be noted that in enacting EPSDT, Congress never authorized limited treatment services; nor has it ever sanctioned HEW's administrative decision to limit coverage of treatment services to vision, hearing and dental services.

[18] 42 U.S.C. §603(g)(3). Essentially, then, states had to at the very least *refer* children who had health problems found in screening. This included informing families whose child needed treatment of the names and locations of health providers offering appropriate services, informing them of transportation services available through the state's Medicaid program, and taking "steps to assist recipients needing

Without question, in some states this policy expanded the services available to children on Medicaid. Prior to the requirement, eighteen states did not provide dental services and eighteen did not provide eyeglasses.[19] However, by failing to require that all treatment services be provided, HEW regulations allowed states to exclude many treatment services children were found to need.[20] For example:

- We were told by a caseworker in Florence County that, in South Carolina, Medicaid paid only for speech evaluations, but not for speech therapy. When a child needed therapy, the best the caseworker could do was notify the school to see what could be done.
- A community worker in Suffolk County told us that New York did not pay for treatment of allergies, even though asthma was reported to be a big problem in the community.
- According to policy statements in Mississippi, Medicaid did not pay for prosthetic devices, or orthopedic shoes. It did not pay to replace lost or broken glasses.[21]

Even within the narrow requirements of the federal regulations, some states have limited the coverage of treatment services still further, thereby denying children care. For example, while hearing- and vision-related problems were specifically to be treated by EPSDT, some states did not pay for certain kinds of therapies (beyond eyeglasses) needed for vision problems. Others placed restrictions on getting hearing aids and eyeglasses. Mississippi, for instance, set its standard for referring a child for vision

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diagnostic and treatment services so that such recipients were able to receive them within a reasonable time period...normally within 60 days of screening." (45 C.F.R. §205.146(c)(iii).)

[19] Medical Services Administration, "Medical Services, State by State, March 1971" (MSA-801-71) (Washington, D.C.: Social and Rehabilitation Service, HEW, 1971). (Mimeo.)

[20] Sometimes Medicaid children who need services for which Medicaid does not pay can be referred to other public programs. For example, see programs described in Appendix E. Whether this happens depends on what other programs exist in the area, what their eligibility and payment policies are, and what specific services they provide. Thus, determining the adequacy of treatment services not underwritten by Medicaid is complicated and time consuming. Our own limited resources did not allow us to explore this in detail. However, we did learn that staff of state Medicaid programs generally did not take into account whether such services were available, at no cost to Medicaid families through other programs, when decisions were made to limit Medicaid coverage. In fact, most state Medicaid officials did not know what specific services were available to Medicaid families through other public programs.

[21] *Mississippi Medical Assistance Act, Screening and Diagnostic Manual*, p. III. 16-17.

problems at 20/50. Some children whose vision is better than 20/50 needed glasses, but as a result of the referral criterion, their eyeglasses could not be paid for. Similarly, even though some children needed frequent prescription changes or replacements, most of our study states limited the provision of eyeglasses and hearing aids to one prescription and one or two replacements every year or two. New Jersey recently discontinued reimbursement for lost or broken eyeglasses except under extraordinary circumstances and with prior authorization.

Dental services, also clearly mandated by regulation, were limited too. A caseworker in Florence County, South Carolina told us:

> I work with a child who had five or six teeth growing in the middle of the roof of her mouth. As is standard Medicaid practice for dental work, an evaluation of the cost of corrective treatment was submitted to the state office. It was returned, "denied" because the state won't pay for dental services which are "cosmetic."

The situation may be getting worse as a result of recent cutbacks by states in their Medicaid programs. From January 1975 through September 1976, seventeen states reduced or eliminated services covered in their Medicaid program. Michigan, for instance, limited vision services for children to one pair of glasses every two years unless a change in vision occurred sooner. In addition, fifteen states reduced or limited reimbursement to providers.[23]

A variety of other state Medicaid policies designed "to safeguard against unnecessary utilization of ...care," limited the effectiveness of EPSDT treatment.[24]

- A clinic director in New York told us that medical providers can be paid by Medicaid for only one claim per child on a given day. But this sensible sounding policy had adverse effects. Staff at one neighborhood health center told us the children who needed more than one kind of treatment could not receive it during the same visit because Medicaid would reimburse the center for only one kind of therapy that day.

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[22] According to the AAP's *Guide to Screening*, children who demonstrate a visual acuity of 20/30 or 20/40 or less, depending on the age of the child, should be referred for further evaluation. (Frankenburg and North, *Guide to Screening*, pp. 113-115.)

[23] Medical Services Administration, Division of Program Monitoring, "Report on Selected Changes: State Medicaid Programs" (Washington, D.C.: HEW, March 31, 1977), Table 1.

[24] 42 U.S.C. §1396a(a)(30); 45 C.F.R. §250.21. Under the Medicaid statute, states have an obligation to establish programs of "utilization control." They can limit the amount of time during which services may be provided; require authorization before services may be performed (see *Medical Assistance Manual*, Part 5, 5-30); and review the necessity of services and decide not to reimburse for them even after they have been performed. However, services covered must be of sufficient amount, scope and duration "to reasonably achieve their purposes." (45 C.F.R. §249.10(a)(5).)

- One dentist in South Carolina complained that the state reimbursed a dentist for only one visit for certain procedures that really take more than a single visit. Similarly, in Mississippi, Medicaid paid only for dental treatment for children up to a limit of $150. And although this limit was relatively high compared to policies in other states in the region, a dentist in Oktibbeha County reported that about 20 percent of the Medicaid children he saw needed dental services exceeding that limit.
- According to one frustrated physician in Michigan:

  > I was seeing a Medicaid child referred to me by the Health Department. In January, I did a hemoglobin and prescribed iron. In February, I did a second hemoglobin, but it was still not high enough and treatment was continued. In March, I did another hemoglobin to see if the child was better, but Medicaid rejected the bill because the child had two hemoglobins already.

Finally, EPSDT is hampered in its ability to improve the health of poor children because of its medical orientation. Medicaid is a program which pays for discrete medical procedures. But a host of children's health problems identified by EPSDT--for instance, nutritional deficiencies, lead poisoning, worms--cannot be dealt with effectively by traditional medical techniques. Referrals to a range of community agencies, counseling or help with a variety of health-related needs (for unmet housing, employment, welfare or child care needs) are often the answer. But Medicaid does not cover these services and rarely do EPSDT providers have the staff or time to offer them. As one physician in Michigan told us:

> Too many times the physician is confronted with limits. The problem is usually bigger than the procedures which Medicaid will pay for. I don't know what the critical mass of staff is, but with kids with these problems you need counselors, social workers, and others. But Medicaid won't pay for these.

Navigating the Treatment Maze

Rodriguez, born 12/30/71, entered the day care program in 8/72. As a result of a group day care appointment, he received his first EPSDT Medicaid screening on 11/26/74, a service he should receive annually. His dental evaluation was marked "OK."

1/14/76 - Rodriguez was referred by his day care teacher to a learning resource center at a state university for a speech evaluation as he "talks funny." The learning center identified the speech problem as caused by an "open bite" dental problem.

1/27/76 - The learning center paid for evaluation by a children's dentist. The dentist verified the problem and referred the child to the county health department for EPSDT screening and dental referral because the last screening did not show dental problems and therefore, Medicaid could not be billed.

2/6/76 - The county health department gave an appointment to

> the child to see the health department physician. The social worker was told that no rescreening could be done if the child had been screened within a year. The physician told the mother that Medicaid does not pay for wires on a child's baby teeth. Nothing was done.
>
> 3/22/76 - The child was screened at a university-based dental hygiene clinic (at the mother's expense). Cavities were found. Nothing was done.
>
> 1/5/77 - The social worker learned that for application for Crippled Children's Special Health Services for Handicapping Malocclusion program, an application must be filled out at the county health department. However, molds of the teeth must be made by a private physician. A call to the state office of Public Health Dentistry determined that they would pay for the molds. However, if the problem is not deemed to be serious enough, the child will not be eligible for Crippled Children's Services.
>
> For treatment of the tooth decay, the child must be rescreened and referred to the dentist by the EPSDT screening done at the county health department.[25]

As of this date, Rodriguez still has not received the needed dental care. His story reflects the burden on children, families and providers imposed by rules in Medicaid and other public programs that further fragment available treatment services. In this case, screening was prerequisite to receiving dental care and children could receive only one screening per year.[26] We found that a variety of arrangements like these made it difficult or impossible to get needed treatment.

The first hurdle in securing needed services for a child was learning what treatment services were available through EPSDT and where and how to obtain them. While there is an explicit federal requirement that families be informed about these matters,[27] we found instances where information was not made plain to the recipient. A mother in Mississippi told us that,

> after the screening, the welfare department gave me a slip which said that two of my children had low blood counts and one had to go to the dentist. Nobody there told me the work could be done for free. I knew I couldn't pay, so I didn't take them.

In other instances, we found that no one--neither the nurse who discovered the health problem nor the person who made the referral for treatment--was given clear responsibility for explaining what Medicaid would pay for.

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[25] Case taken from a letter from Michael Raff, Executive Director, Mississippi Council on Human Relations, to Senator Theodore Smith, Mississippi Senate, 17 January 1977.

[26] We have learned that partially as a result of the work of the Mississippi Council on Human Relations, the policy which prevented Rodriguez from getting needed dental care has been changed.

[27] States must "inform recipients in need of diagnostic and treatment services of the names and locations of health providers offering such services, and of the transportation services available...." (45 C.F.R. §205.146(c)(iii)(A).)

The second hurdle was finding and getting to the services. Frequently, even the simplest kind of needed follow-up care was not provided at the time or place of screening. In Michigan, counties were encouraged to give needed immunizations at the time of screening. However, Genesee County did not do so because immunization clinics and records were housed in a part of the health department building separate from where screening clinics were held. Because it would be difficult to transfer and update immunization records, people who did the screening did not do immunizations. Nor did they send children directly over to the immunization clinic, because sessions were not held at the same time as screening clinics. Similarly, while families in Genesee County could receive basic nutrition counseling at the time of screening, this was not the case for shots, iron pills and the like. Children who did not have their own doctor were rescheduled for a well-baby or a general medical clinic held at a later time.[28]

There were other hurdles as well. Most states have established policies requiring families to get prior approval for certain treatment services. As we have already seen, such policies actually denied children access to needed care.[29] They also caused families the time, expense and inconvenience of making yet another trip to the doctor before treatment could be begun. For instance, in South Carolina, Medicaid paid for cardiac and orthopedic care only if the child had been referred by a physician. In Florence County, to be referred by a physician, a child had to return to the Health Department during a pediatric clinic (held one Wednesday each month or, for emergencies, other times were available in neighboring counties) before treatment could proceed.

Parents often told us of endless waits, numerous visits as a result of authorization requirements, and appointments at times of the day that made them lose a day's pay or their children a day's schooling. All this added up to a level of frustration that in some cases outweighed the benefits potentially available from treatment. In Michigan, one mother said:

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[28] This was the usual practice also in South Carolina and Mississippi, where treatment services offered by county health departments were provided at specialty clinics held at a time other than screening. Even though maintaining these categorical clinics interfered with the smooth operation of EPSDT services, we found that, for the most part, health departments had not restructured these arrangements.

[29] For example, making screening a prerequisite for dental or other kinds of treatment.

> I took all my children to be screened at the Health Department. The two youngest needed some shots, but they told me they couldn't get them then. It seems like *every time* I get ready to take them back one of them gets sick and we can't go.

In Mississippi:

> After screening was over, two of my children had to come back later so they could get pills to build up their blood. My boy went to the dentist. The first time they didn't do anything but look and tell us we'd have to come back again to get the work done. I work and I think many more people would go to screening if it were held on Saturday and if we didn't have to go through all this afterwards.

The Importance and Inadequacy of Follow-up to Referrals

Sam, a youngster in Starkville, Mississippi, went to the Health Department last summer to be screened. The screening detected several of Sam's teeth were very decayed and Sam was referred right away to a dentist, whom he saw. The dentist told Sam that a lot of his teeth needed to come out, but instead of pulling them then, Sam should wait until the dentist had a chance to call the welfare department. Then he would contact Sam again. His parents never heard from the dentist's office. A day care worker at the center where Sam's younger sister went heard about the situation and called the dentist's office on Sam's behalf. She was told that the dentist didn't do the kind of work Sam needed. So, many months later, his severe dental problem had gone untreated and there were no indications that anyone who could help knew about his case.

Given the obstacles between screening, diagnosis and treatment described above, follow-up services are crucial.[30] Data from across the country make clear that it is essential to have adequate staff for follow-up. A study of the Barrio Comprehensive Child Health Care Center in San Antonio, Texas--a federally-funded EPSDT Demonstration Project--revealed that only 21 percent of problems detected were known to be corrected. The evaluation found that "case monitoring is an activity which received low priority even in this project which emphasizes comprehensive health care....Case-monitoring efforts tend to be sporadic and non-cumulative, since they are done during slack periods in other clinic activity and by volunteers, when available."[31]

Similarly, a 10-county audit of North Carolina's EPSDT program showed that follow up was documented for less than half the referrals made. By contrast, in the one county "that had a person specifically responsible for case management," there was documented follow-up for 90 percent of children needing treatment.[32] Yet, follow-up is one of the most difficult aspects of the program to carry out properly. We found that for a host of administrative reasons, states generally did not have effective tracking procedures.

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[30] Although HEW has not mandated that states use any specific tracking system (*Medical Assistance Manual*, Part 5, 5-70-9.00, Question 28), guidelines specify that states must have procedures to identify individuals who need treatment services but have not received them. (*Medical Assistance Manual*, Part 5, 5-70-30(A)(1)(c).)

[31] Fred Fielder and Harold D. Dickson, *The Barrio Comprehensive Child Health Care Center, November 1972 - June 1975, Final Evaluation Report* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, November 1,1975), pp. ii and 20.

First, rarely was follow-up clearly assigned to one agency or individual. South Carolina's policies and description of the program revealed that responsibility was placed with both local departments of health and social services.[33]

At the local level, Oktibbeha County split responsibility for follow-up between the welfare and health departments with equally unsatisfactory results. The District Health Officer told us that welfare department staff followed up children who were referred for vision, dental or hearing problems, and health department staff followed up other kinds of referrals. But when we talked with staff at the local welfare department, they told us that caseworkers made the judgments as to which cases were most important for them to follow, and they tended to follow heart ailments and anemia --the same problems which health department workers said they followed.

Second, there were insufficient staff or time to do follow-up. And third, even where follow-up efforts were made, we found that technical weaknesses in data and reporting systems often caused expensive, time-consuming efforts to be ineffective. In Michigan, for example, there were several follow-up techniques. Each approach, however, had its shortcomings. One approach was for the Medicaid agency to review bills submitted by providers for Medicaid payment to see which children had received services after screening. But some organizations which treated children (like the health department and the mental health clinic) did not bill Medicaid because the care was paid for through other federal funds. This meant that some children who had been treated did not show up as treated on the Medicaid printouts. And not all children for whom a Medicaid bill was submitted received treatment for the particular problem found in screening. Instead, they may have made a visit to the doctor for a sore throat or some other reason unrelated to the problem found in screening, which may have remained untreated. In fact, this happened frequently. In one small sample done in Michigan, the medical procedure indicated on the billing invoice from the subsequent visit was related to the problem found in screening for only 38 percent of children.[34]

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[32] Division of Social Services and Health Services of the State of North Carolina, Department of Human Resources, *Report on the Audit of the Administration of the Early and Periodic Screening, Diagnosis and Treatment Program, Title XIX, for the Period July 1, 1973 through March 31, 1975* (Washington, D.C.: HEW Audit Agency, Region IV (Audit Control No. 04-60201), p. 12.

[33] See *Child Health* (Manual), State of South Carolina (undated); Program Administration and Management, *Positive Program Practices*, South Carolina Medical Services Administration ((SRS) 76-24518); Regional Office Assessment of South Carolina's EPSDT program for quarter ending September 30, 1975; and "Contract: South Carolina's Department of Social Services Agreement for Purchase of Early Screening Services," State of South Carolina, 1 July 1972.

A second follow-up approach in Michigan was using a referral form to be completed by physicians and returned to the health department for children receiving treatment services. This, too, had its limitations. We were told that many physicians returned the slip quite late, so that prompt follow-up for missed appointments was impossible.[35] In addition, certain kinds of referrals--immunization, for one--were not logged by health department staff at the end of a screening clinic. Consequently, there was no way to know that referrals were made or to watch for them to be completed.

Finally, the third approach was interviewing families by welfare caseworkers during their regular visits for recertification. This, however, was not done consistently. Genesee County caseworkers told us that they tended not to inquire about what services had been received unless they were aware that a family member had a serious health problem. In a statewide survey of Medicaid families, 65 percent reported that they had never been asked by their caseworker whether treatment was received.[36]

In Mississippi, a computer system was designed to track treatment services provided through EPSDT, but it tracked only three kinds of referrals--hearing, vision and dental. Even for these, staff doing follow-up received the printouts only sporadically. Staff in the Oktibbeha County welfare agency told us that it had been "quite a while" since they had received a listing of children who had not yet been treated for hearing, vision or dental problems. In certain circumstances, children were dropped altogether from the follow-up listing. Apparently the reason Sam (discussed above) was not followed was that children who received *diagnosis* appeared to the computer as "treated", and then fell out of the tracking system. In addition, children who had been referred but had not been treated within 150 days of screening were dropped from the computer listing. Follow-up mechanisms in our other study sites suffered from similar problems, with the result that follow-up efforts were generally ineffective.[37]

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[34] Interview with Thomas R. Kirk, M.D., Chief, Division of Child Health, Michigan Department of Public Health, 3423 Logan Street, Lansing, Michigan 48906, 22 October, 1975.

[35] We were told that, statewide, approximately 50 percent of physicians never returned the forms. Interview with Thomas R. Kirk, M.D., 22 October 1975.

[36] Special questionnaire survey to assess the effectiveness of the Department's efforts to inform clients of the program and to assist them in using it, and of clients' response to those efforts," conducted by the Department of Social Services, State of Michigan (Lansing, Michigan: Department of Social Services, February 1975).

We found also that appropriate community agencies and staff outside of the welfare agency who could effectively do follow-up were neither encouraged nor permitted to do so. CAP agencies and Head Start centers, for example, through their regular contact with families, carried out follow-up in an informal way, but they had no clear mandate to do so and received no Medicaid reimbursement for their work.

As with outreach, refusal to share information with community organizations limited the help they could provide in following up on children's health. Head Start staff in Genesee County told us they were

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[37] South Carolina had a computerized system whose effectiveness was limited by the tardiness with which treatment providers sent in the forms and the difficulty of determining whether treatment received dealt with the problem found in screening. Staff of the County Department of Social Services planned to set up a card system to keep track of the defects found and the treatment received. In addition, there were plans to have the state send a copy of the treatment form to Health Department staff, once the referral was completed. However, at the time of our visit to Florence County, Health Department staff who made referrals had no way to learn the outcome of those referrals supposedly followed by the Department of Social Services.

Staff of the program in Suffolk County, New York were trying to work out a system so that people in the county welfare agency could monitor follow-up. There the problem was complicated by the fact that different kinds of providers were given follow-up responsibility and each carried it out differently. The Health Department was to follow up children screened in its clinics, and private physicians were to follow children they screened. Due to a variety of technical problems in the flow of forms and computer printouts, similar to those we found in our other study sites, staff of the Department of Social Services, who were supposed to identify children who were missed, were unable to do so.

New Jersey's follow-up system is probably the most elaborate. But two aspects of the system resulted in its being ineffective in assuring that needed treatment was received promptly. In order to follow an individual child in New Jersey through the treatment phase of EPSDT, a screening reporting form which plugged into the computer system must be used by whoever screened a child. However, Medicaid reimbursement levels made it in the financial interest of most screening providers--private physicians, hospital outpatient departments, and neighborhood health centers--to bill a screen *not* as a screen but rather as an "office visit." So, many providers who screened children did not fill out the screening forms and, as a result, the child was never in the tracking system.

In New Jersey, most children were screened by private physicians and the physicians with whom we spoke tended to use screening forms. The second weakness in the system was that it relied on screening providers submitting information to unable to find out whether children in their programs had been screened and whether needed treatment had been received. In Florence County, Head Start staff got copies of children's health records from the health department, but the information was usually only about screening and not about whether referrals had been completed. The problem for Head Start in Suffolk County was aggravated by the fact that children were screened by many different providers, and keeping track of the EPSDT status of Head Start children required dealing with an enormous number of clinics and private physicians.[38]

Providers of Treatment Not Available

It is well known that health manpower and facilities are distributed unequally and in many areas of the country are inadequate. Eight hundred and ninety-four counties are considered by HEW to be critical medical shortage areas and 777 counties or areas have critical dental shortages.[39] This problem is not peculiar to EPSDT, but it severely hindered getting treatment to eligible children. An outreach worker in Florence County told us:

> If you don't have a doctor, you're just out. There aren't many doctors. The ones we have are overloaded and won't take any new patients.

To make the inadequate supply of resources worse, many providers refused to participate in the Medicaid program or took only a limited number of patients. According to an HEW report:

> [I]n some States (e.g., Florida) as few as 30 percent of physicians participate in Medicaid, and nationally only about half of all physicians are participating as Medicaid providers. In cities across the South (Raleigh, Jackson, Mobile, Jacksonville, and New Orleans) it is still common for physicians to refuse to take Medicaid patients. Just 41 percent of

the state office promptly on referrals. But, for purposes of getting reimbursed for services, providers were allowed 90 days from the time the service was provided to submit a claim and, although they were encouraged to submit screening claims within 30 days, many did not. Once claims were submitted to the State, additional time was needed until the information was programmed and a printout sent back to staff in the county welfare agency. Thus, it was virtually impossible for staff to identify, within two months of screening as required by law, those children who had not received treatment. The large caseload--approximately 200 families per caseworker--diminished even more the likelihood that prompt follow-up took place. (According to recent correspondence to us from a state Medicaid official in New Jersey, some of these procedures have been modified since our visit.)

[38] In using a variety of organizations to do follow-up, the issue of protecting families' and children's confidentiality is even greater than it is with outreach. EPSDT regulations mandate that careful procedures be established to assure confidentiality of health history information. See *Medical Assistance Manual*, Part 5, 5-70-20(E)(5).

[39] Public Health Service, Manpower Analysis Branch, "Critical Health Manpower Shortage Areas Designed for Purposes of the National Health Services Corps as of September 1, 1976" (Washington, D.C.: HEW, 1976).

> dentists will see Medicaid patients.[40]

And there is evidence to suggest that the situation is getting worse. A survey conducted in Michigan found that acceptance of new Medicaid patients among physicians had dropped from 83.5 percent to 68.3 percent.[41]

In three of our study sites--Oktibbeha, Florence and Suffolk counties--we were told there were insufficient providers for children with general pediatric problems such as anemia, lead poisoning, respiratory problems and so on.[42]

In the states with health department-based EPSDT programs, the gap was partially filled by general medical or pediatric clinics, but these were held infrequently, perhaps one morning once each month. As a result, treatment for infections and other acute problems was delayed. According to reports by HEW, the situation in South Carolina was serious:

> The number of physicians and dentists who participate in the Medicaid program statewide are insufficient to provide treatment for the eligible population identified with physical and dental defects.... For some eligible individuals it is necessary to cross state lines for treatment. Diagnosis and treatment may not be provided within the normal 60-day limit.[43]

In Florence County, specifically, we learned that there were five physicians in the Lake City area. Three were in a group practice which was not taking new patients. The other two were in solo practice, but

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[40] According to HEW, "even these figures may be overestimations since a single Medicaid billing is often sufficient for a provider to be counted as 'participating.'" ("EPSDT: The Possible Dream," p. 3.) See also M. Elaine Gilliard, *Medicaid for the Young--The EPSDT Program in the South* (Atlanta, Ga.: Southern Regional Council, October 1976), pp. 24-25.

[41] Bureau of Economic Information, "Michigan's M.D.s Taking Fewer New Medicaid Patients," *Michigan Medicine* (May 1976), p. 240.

[42] While staff in the communities we visited told us their experiences, quantitative information about the adequacy of resources was scarce. One source of data was county analyses of the number of active physicians, nurses, dentists and hospitals per 100,000 population. (See "Selected Measures of Health Manpower, Facilities, and Education, by Health Area" (Washington, D.C.: Health Resources Administration, Public Health Service, HEW).) But they did not indicate whether there were sufficient providers who offered the particular services needed (whether they were general medicine or specialists such as orthopedic, optometric or cardiac), nor whether they participated in Medicaid, nor if they did participate in Medicaid, whether they were accepting "new" patients referred through EPSDT.

Because state Medicaid agencies processed claim forms in order to pay providers for services rendered through Medicaid, they must have information, in some form, on participating providers. In many cases, however, this information was not assembled, so there was no up-to-date roster of providers who saw Medicaid patients. Nor was there a listing of the specific services they provided and where they were located. In only one of our study sites were we able to get such a list. It was put together by staff in the county Health Department so that they knew to whom to refer children for various problems.

[43] "HEW Regional Office Assessment of South Carolina EPSDT Program for Quarter Ending September 30, 1975," p. 2.

Medicaid patients were told that neither of them was accepting new Medicaid families either. The Health Director of a Head Start program in Oktibbeha County reported:

> Finding treatment services for Medicaid children is a terrible problem. I sent a letter to all doctors in the area, asking if they would accept Medicaid patients. They all said they would in an "emergency," but so many of the health problems here can't truly be considered emergencies. The one pediatrician in town will see Medicaid children only on a referral basis.

In some places, like Suffolk County, publicly-funded clinics provided routine health treatment but, already overburdened, many of these programs could not offer appointments to families promptly. A community worker in Suffolk County said:

> Doctors are so booked up they can't see patients for a long time. In the meantime, the parent or child gets busy with other things, maybe forgets the time of the appointment, and moves on to another problem in life.

For medical *specialties* (such as problems of the heart, ears, eyes, bones or nervous system), many places lacked adequate health resources--particularly cardiologists, allergists, dermatologists, ophthalmologists, neurologists and dentists. According to staff of a health center in Suffolk County:

> Our problem is specialists. Kids who have allergies or cardiac or orthopedic problems are put on a waiting list for a year.

We randomly contacted about half of the dentists in Florence County, South Carolina to find out whether they were involved in EPSDT or Medicaid. We found that:

- Five practiced in a specialty clinic which did not take Medicaid patients;
- Five others chose not to accept Medicaid patients;
- Two did dentures only;
- Two accepted Medicaid patients for extractions only;
- Two saw Medicaid children every other Wednesday only;
- One took Medicaid patients but the nurse was unsure whether new patients would be accepted; and
- One accepted Medicaid patients without qualifications.

In Essex County,

> It's the children with special problems who are referred out and have a harder time getting treatment--especially for cardiology and psychology services... We need more specialists here. Those we have are not conveniently located.

In Oktibbeha County, we were told that the waiting period for a dental appointment for EPSDT children was about six months.[44] Staff at the county welfare agency also reported that "the only eye doctor in town is booked three months in advance."

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[44] According to reports of state and HEW officials,

> Diagnosis and treatment services present some problem for Mississippi. A severe dental manpower shortage coupled with the fact that a large percentage of the referrals are for dental services causes delays in the child's receiving these services.

"Mississippi EPSDT Implementation Assessment, Narrative Report for Quarter Ending September 30, 1975," p. 2.

The problem existed in New York, too. Staff at one public health center in a poor, predominantly Spanish-speaking area in Suffolk County told us the center's Medicaid patients generally waited a year for an appointment for treatment for allergies or for cardiac or orthopedic problems.

Why were providers of treatment not available? Compounding the general maldistribution and inadequacy of certain kinds of health resources was the fact that gaps were not identified and resources were not developed where they were needed. Further, administrative problems kept existing providers from participating in Medicaid. In comments on EPSDT's revised penalty regulations which were published for comment in August 1975, 20 of the 33 states and 10 of the 15 localities which responded discussed "provider problems related to shortages in certain geographic areas and/or Medicaid participation."[45]

Developing Needed Resources

Since EPSDT's inception, it has been assumed that treatment resources existed in sufficient supply to meet health needs detected in screening. Yet while there has been widespread evidence of and concern for the lack of resources for EPSDT treatment, HEW and the states have done little to develop resources where they are needed.[46] By and large, they have not collected information to determine where or what kinds of treatment resources were in short supply. And with few exceptions they have not developed them where needed.[47] HEW had a contract with the American Academy of Pediatrics to encourage participation by providers in each of HEW's ten regions, but the emphasis was on private pediatricians, and attracting dentists and a variety of other providers was neglected. In our study sites, staff of local agencies often knew where the resource shortages were, but exactly what steps a state or county agency (either health, welfare or Medicaid) was taking to develop Medicaid providers, few could say.

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[45] Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," p. 125.

[46] According to Anne-Marie Foltz, who has studied extensively the early history and development of EPSDT,

> Since most states claimed they provide curative services on demand under the regular Medicaid program, the emphasis placed by HEW was on preventive care or screening....The diagnosis and treatment part of the program, if not ignored in guidelines, planning, and monitoring, at least was not stressed.

(As cited in Foltz, "EPSDT: Lessons for National Health Insurance for Children,"p.9.)

[47] There are no funds available through Medicaid to develop new clinics or resources where needed. However, having identified service gaps, program administrators could work to obtain needed funds or manpower in a variety of ways: from other sources of federal funds or manpower programs (such as the Rural Health Initiative Program, the Health in Underserved Areas Program, the National Health Service Corps) or from state appropriated funds.

Encouraging Existing Providers to Participate

Among the reaons the American Academy of Pediatrics found for why physicians chose not to participate in Medicaid were, in order of frequency:

- insufficient communication with state administrators;
- lack of physician familiarity with EPSDT;
- inadequate or delay in payment with fees;
- physicians not allowed or encouraged to participate; and
- forms too complex or not designed to document the child's health.[48]

We found that four similar themes recurred: reimbursement was slow and low; there were mountains of paperwork; Medicaid's rules made it impossible to provide effective health care; and physicians did not know about EPSDT or how they could participate in it.

On the subject of reimbursement levels, we heard:

- Originally Medicaid paid me $13 for an office call. Suddenly, without notification, they started paying just $10. The rates aren't constant and payment is sporadic. I get a lot of rejected bills because of a lapse in the patient's eligibility or because someone in the Medicaid office thinks a diagnosis is inappropriate.... Three years ago, I stopped taking Medicaid patients because I got fed up with the arbitrary decisions about what would and would not be paid for and because Medicaid owed me $8,000. Then my patients went to the emergency room. They gave my name as their doctor, and they were being referred back to me. These circumstances forced me to take Medicaid again. Sometimes I sound bitter, but I have really had a lot from this Medicaid.
- In New York Medicaid fee levels are 50 percent of "reasonable and customary charges," and only about half of the physicians in Suffolk County are reported to participate in Medicaid. Medicaid dental fees "are terribly, overly low. Some aren't much better than dental student fees while they're in school." Because Blue Cross/Blue Shield pays the full cost of dental services, dentists opt to take persons covered by Blue Cross/Blue Shield, and not to see Medicaid patients.

The slowness of Medicaid reimbursement compounded the problem of low fees. In fiscal 1974, 16 states had reimbursement time lags which exceeded one month; 20 states had a 2-month lag; 11 had a 3-month lag; and three states took from 3 months to 3 years to reimburse providers.[49]

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[48] American Academy of Pediatrics, *Increased Professional Provider Participation in State and Local EPSDT Programs* (Washington, D.C.: Medical Services Administration, Social and Rehabilitation Service, HEW, June 30,1976), p. 13.

[49] George P. Tolbert, *Third Party Payor Assessment* (Final Report on the Third Party Payor Questionnaire) (Washington, D.C.: Division of Health Services Financing, Bureau of Community Health Services, Health Services Administration, Public Health Service, HEW, March 20, 1975), p. 13. (Mimeo.)

The situation has grown steadily worse. Typical complaints were:

> I don't get paid for my services with any frequency. At one point I didn't get any money for six months. They are behind now in about 40 percent of the payments.

> The back-up pediatrician for our day care center has stopped accepting Medicaid patients because he is not paid on a timely basis. He will see the children on an emergency basis, and will still see old Medicaid patients but many new Medicaid children have a hard time finding a doctor who will see them.

Providers also said they avoided Medicaid because of the paperwork requirements. From a nurse in Michigan we heard:

> For each Medicaid patient the doctor sees, I spend about 10 minutes filling out papers for every visit. This is not medical history information--it's just forms with identifying information so we can be reimbursed. Paperwork for Medicaid patients takes me twice as long as for other patients.

From a physician:

> The drawbacks of Medicaid.... When I started working with it, I had to hire a clerk just to fill out forms. Now she can't keep up with the paperwork it generates.

These complaints were ironic in view of how little useful information was available to gauge the program's strengths and weaknesses. In fact, when we studied the various forms Medicaid providers filled out, we found that the vast majority of them were for getting the state's approval for reimbursement and for getting reimbursed. Few questions were for the purpose of planning or managing EPSDT.

Furthermore, complaints about forms were, in part, an expression of dissatisfaction with low and rigid reimbursement rates rather than with the forms themselves. Most private insurance companies require many forms, but they pay higher reimbursements than Medicaid. Also, the provider can bill the patient for charges not picked up by the insurer. One way or another, the provider's time is paid for. If EPSDT reimbursement rates were high enough to be attractive to providers, we doubt that reporting requirements would be such a barrier to participation.

Physicians also told us it was unrewarding to provide health care through Medicaid. For instance, rapidly changing eligibility meant families rarely had the kind of ongoing relationship with a provider that encouraged proper use of health services. As one physician reported

> The "old" Medicaid patients who we've seen for a long time get to know how to use services better. But you know there aren't many "old" Medicaid patients.

Similarly, loss of eligibility also meant that long-term treatment could not be paid for and, as a result, children returned months later with the same problem. In addition, Medicaid often did not cover support services (such as counseling or referral to other community agencies) which were needed to help with health problems.

Some of these complaints were legitimate and can be addressed by making administrative changes in the Medicaid program. Some cannot. But states must do all they can to ease those problems that can be eased. And they must strongly urge providers to participate even though not all their complaints can be remedied.

In the few places where such efforts had been made, significant benefits were reported. Although getting dental providers in South Carolina remained a problem, important progress had been made. South Carolina's EPSDT director told us that:

> One of South Carolina's most effective moves was to hire a dental consultant who works part-time for the State Medicaid agency. He has made it his business to attract new graduates from dental school into the program. Medicaid can provide these young dentits with their first "regular" business. Also, he's helped negotiate special dental contracts with about 10 various organizations.

In Suffolk County, the local Medicaid agency employed a full-time dental and medical director who helped local providers work through administrative problems and has accomplished good public relations with providers and relatively high participation rates.

We found, however, that these activities were the exception. Generally, state Medicaid agencies had not taken sufficient steps to inform providers about EPSDT, to actively encourage their participation or to attempt to overcome or lessen the administrative problems providers encountered. Most state agencies sent letters or memoranda to providers who were already participating in Medicaid explaining briefly what EPSDT is. But providers who were not already participating in Medicaid were not informed at all. Occasionally, articles about EPSDT have appeared in state or local medical journals, and sometimes EPSDT has been a topic of discussion at a meeting of a state or local pediatric or medical society. The results of these less than vigorous efforts have not been impressive. From a physician in Michigan:

> The private medical community was never systematically informed of the EPSDT program. I first heard about it when two thick manuals about the program appeared on my desk but without any cover letter of explanation. There should have been a lot more informing and workshops held at the local level. It just doesn't work to have a statewide conference.

And from New Jersey:

> In April of 1975, a Medicaid family came to the outpatient department of our hospital carrying a slip received from the welfare department. The clerk on duty was baffled by the initials EPSDT and called me (the main clerk, who at the time, was at home, sick) for advice. I, too, didn't know those initials, and instructed her to call the lab, assuming they must stand for a lab test.

Recommendations

1. Title XIX should be amended to allow all individuals age 21 who have been assessed to remain eligible for Medicaid services for one year following an assessment.

2. Federal regulations must be modified to require that states provide all health care indicated by an assessment and all needed outpatient health care following an assessment. If such services are available at no charge through other programs, states must at least make sure that children eligible for Medicaid receive needed services promptly and provide transportation and other needed assistance to make them accessible. Federal regulations must make explicit that states cannot establish referral criteria which deny children needed follow-up care.

3. HEW policy should clarify that all eligible children are entitled to Medicaid services covered under the state plan, regardless of whether they have been assessed.

4. Federal performance standards for providing treatment through EPSDT should be issued immediately. They should require that at least 90 percent of the children who have problems found in an assessment have begun treatment after a 60-day period. Certain minimum procedural standards must also be defined by federal regulation. State plans must demonstrate how the standards are being met. Specifically, states must demonstrate that: (a) there is a working system of follow-up, including: clear assignment of responsibility for follow-up; and staff capacity and a system of record keeping which allow for the prompt identification of those children who have not received needed care; (b) sufficient efforts have been made to attract providers into the Medicaid program; and (c) sufficient efforts have been made to develop new resources unless states can demonstrate adequate resource capacity to treat general and specialty pediatric problems promptly.

5. HEW should issue a policy directive that simple treatment procedures, as indicated, be done or at least begun at the time of screening. At the very least, providers of assessments should have the capacity to give, at the time of screening, immunizations, information about child growth and development, nutrition counseling, medication for anemia and topical medication for rashes. Providers of assessment who cannot offer such treatment, but who exist in medical shortage areas or have gained unusually strong support from the community, should continue to assess children so long as they have an effective mechanism for referral and follow-up.

6. HEW should revise federal EPSDT reporting requirements to include information on the proportion of health conditions needing follow-up care for which care was received

promptly. In order to secure such information, states could, for example, include on provider billings a special code indicating what type of services were provided as a result of an assessment. If the provider of follow-up care is different from the assessment provider, persons who make the child's appointment for follow-up care (e.g., a caseworker or parent) should notify the provider that the child has been referred following an assessment for a particular problem.

7. Congress should establish a program to develop needed resources to provide primary care services. (For more discussion of this recommendation, see recommendation 1 in Chapter 7.) In addition, the federal EPSDT office should enter into agreements with other federal programs which provide funds or personnel to build health resources in underserved areas (such as the National Health Service Corps, Health in Underserved Rural Areas, Rural Health Initiatives), to give priority in funding new programs to areas where EPSDT has identified shortages. The federal EPSDT office should provide state and county EPSDT administrators with complete information on federal programs available and on how local communities can apply for funds or manpower through these programs. HEW should also encourage states to use the information on resource shortages, generated by EPSDT data, to encourage state legislatures to develop new programs where needed.

8. State and county medical and pediatric societies should take the lead working with providers to assure that for any child not treated at the time of the assessment, the provider has staff and a system for following up referrals or has arrangements with the state agency for doing so.

Chapter 6

Attending To Children's Developmental Needs

Why Is It Important?

Kenny is a 14-year-old black child in Canton, Mississippi. The last time he was in school was in the third grade. The reason: he is partially sighted. The troubles began when Kenny couldn't see the blackboard or keep up with the work done in class. Quiet and shy, he grew more and more hesitant because of his handicap. His teachers, not knowing the cause of his slowness, had little patience. One slapped him when he did not move out of her way fast enough. Another told his mother that she "didn't have the time to teach him." When a third teacher teased Kenny and called him "a fool," his mother took him out of school.

After tests were done to determine Kenny's vision problems, his mother tried to enroll him in school again. But by then Kenny was several years behind in his schoolwork and the principal said he would have to be placed in a class with children much younger than Kenny. Already embarrassed because of his poor vision and ashamed of his missed years at school, Kenny refused to go to school. He remains at home, unhappy and falling further and further behind his friends.

EPSDT was intended to find the "Kennys" and others like him who suffer the consequences of disabilities that impede their growth and development. Kenny is not an unusual child. Developmental problems are among the most prevalent conditions affecting the child population:

- Between birth and age 19, approximately 2.3 million children are speech impaired, 2.0 million suffer from learning disabilities, 1.5 million are mentally retarded, 1.3 million are emotionally disturbed, 328,000 are crippled and impaired children, 328,000 are hard of hearing, 66,000 are visually handicapped, and 49,000 are deaf.[1]
- The combined group of mentally retarded, seizure disorders, neuromotor disabilities, school learning problems and emotional disturbances exceeds 17 percent of children, a percentage that is higher than most other conditions, such as anemia, tuberculosis, etc.[2]

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[1] Kurt J. Snapper, Harriet H. Barriga, Faye H. Baumgarner and Charles S. Wagner, *The Status of Children 1975* (Washington, D.C.: Social Research Group, The George Washington University, 1975), p. 27.

[2] William K. Frankenburg and A. Frederick North, *A Guide to Screening for the EPSDT Program Under Medicaid*, prepared by the American Academy of Pediatrics (Washington,

- The most prominent of the child health problems that have emerged in the past decade or two are the behavioral and schooling problems found in children of all ages. Between 20-30 percent of children entering first grade have been identified as having behavioral and emotional problems.[3] The prevalence of preschool behavioral problems in various populations varies from 8-50 percent[4], and 10-30 percent of school children experience significant learning problems or behavioral difficulties.[5]

These figures are for the child population as a whole. As with other childhood illnesses, the incidence of these problems among poor children is high. Data from the EPSDT Demonstration Projects experimenting with the developmental assessment part of the program have shown a significant number of developmental problems among the eligible children they serve. The National Capital Day Care Association Project, an EPSDT program based in a child care program serving primarily inner-city, black children, found that 22 percent of those screened for developmental problems were found to need treatment. Of these, 5 percent had serious problems and 40 percent had a lag in at least one of four areas: language, cognition, visual-motor or memory skills.[6]

The Cuba-Checkerboard EPSDT project in New Mexico found that 15 percent of the children screened for developmental problems needed further diagnosis; 5 percent of this 15 percent had "serious problems;" 85 percent of them were identified as having one or more problems in four areas tested: intellectual, visual-motor, emotional or language.[7]

There are a number of important reasons why developmental problems such as these should be found as soon as possible. First, some of these disabilities can be most effectively treated when the child is very young, and are less susceptible to remediation the older the child gets. For example, amblyopia (loss of vision without obvious organic cause) can be most effectively treated before the age of 6 years. Afterwards, the rate of response lowers dramatically. Second, if left untreated, the disabilities' effects get worse.

D.C.: Social and Rehabilitation Service, U. S. Department of Health, Education and Welfare, June 1974), p. 141.

[3] Robert Haggerty, et al., *Child Health and the Community* (New York: John Wiley & Sons, 1975), p. 95.

[4] Haggerty, et al., *Child Health and the Community*, p. 99.

[5] Haggerty, et al., *Child Health and the Community*, p. 101.

[6] Harry W. Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, January 1976), p. iv.

[7] Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975*, p. iv.

Third, if untreated, many disabilities have secondary effects which enormously exacerbate a child's problems and complicate their treatment. For example, a child who cannot see properly may need glasses, or a stutterer may need counseling or speech therapy. Leave these conditions unnoticed or untreated and the child is likely to fall behind in schoolwork, have difficulty in social relationships, be inhibited or angry or frustrated, develop learning or emotional disabilities and be caught in a downward spiral of academic and social failure.

To pick up these problems, EPSDT legislation mandated ascertaining children's "physical or mental defects...."[8] The aim was to identify a wide range of problems that interfered with the normal and healthy development and growth of children, with their ability to learn, to cope and to function. However, more than any other part of the program, this aspect--screening for "mental defects"--has sparked controversy.[9] Debates continue to rage about the appropriateness of this aspect of EPSDT and about whether and how it can be carried out.

Why is Developmental Assessment So Controversial?

The Complexity of Development

There has always been uncertainty about what is meant by screening for mental defects. No definitions appear in the law or regulations, but the guidelines call for an assessment of an individual's physical and mental health, through a developmental history and a developmental assessment.[10]

> This part of the screening procedure should include assessment of eye-hand coordination, gross motor function (walking, hopping, climbing), fine motor skills (use of hands, fingers), speech development, self-help skills

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[8] 42 U.S.C. §1396d(a)(4)(B).

[9] See Appendix D for a list of other organizations' views about the developmental assessment component of EPSDT.

[10] *Medical Assistance Manual*, Part 5, 5-70-20(B)(1). There are various opinions about the significance of the difference in the language used in the statute (which calls for screening for mental defects) as opposed to that in the guidelines (which calls for a developmental assessment). Some say the change was made to broaden the category to assure that mental retardation and other developmental and learning impairments and disabilities would be identified and treated. Furthermore, screening for mental health defects had dangerous implications, particularly in terms of labeling, and the change to "identify problems of growth and development" had fewer harmful implications for children. (Interview with Phyllis Dichter, formerly staff member, EPSDT Office, HEW, 13 May 1976.) Others said "developmental assessment" got at *both* physical and mental defects and it was for this reason this component was added, not because it replaced screening for mental defects. (Interview with Lucille Reifman, Associate Deputy Commissioner of Planning, Medical Services Administration, U. S. Department of Health, Education and Welfare, 8 June 1976.)

> (dressing, eating, personal care), and behavioral development.[11]

The details of how this is to be done have never been spelled out. No procedures were mandated and a developmental assessment was defined only in the general terms quoted above.[12]

The reason for this lack of specificity cannot simply be attributed to administrative laxity. The problem is more fundamental. Human development is a complex process: it goes on throughout life, includes both a person's strengths and weaknesses, and involves the style and competence with which an individual functions in many different situations. It includes a child's performance in different settings--in school, at home, with friends--and is affected by a wide range of factors--age, experience, general physical condition, cultural and physical environment. The areas of development fall into three broad categories.

First there is *physical development*: gains in height, weight, head circumference and gains in the control children have over their bodies. This control is called motor development, that is, learning to hold the head up, to roll over, to bring the hands up to the face, to watch objects, learning to sit, crawl, and walk, and later to stand on one foot, skip, or to use a crayon or pencil. All children follow a similar pattern of development in this area, though the exact ages at which certain milestones are reached differ within a certain range, even in normal children.

The second area of growth is in *cognitive development*: the increasing knowledge and learning skills children acquire and their ability to use them in thinking through problems and making decisions. It involves memory, perception, imagination and organization. While cognitive development is a separate category of skills, it is very dependent on physical growth progressing normally. A child's ability to hear, to see, to use language and to move around and explore, all can affect cognitive development. Mastering language is a major achievement. It includes being able to pronounce words and build sentences. Problems with hearing or sight or trouble in speaking clearly

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Finally since there was no legislative history in this area, no one knew what was intended by the statute. The language in the guidelines was intended to be broad enough to provide a liberal interpretation for any state that wanted to take an initiative in this area, but narrow enough to provide an opportunity for the federal office to limit activities of states later if that was necessary. It was a stop-gap solution to a long-range problem. (Interview with Barney Sellers, National Health Council, 19 July 1976.)

[11] *Medical Assistance Manual*, Part 5, 5-70-20(E)(7)(c).

[12] *Medical Assistance Manual*, Part 5, 5-70-20(E)(7)(c); and Frankenburg and North, *A Guide to Screening for the EPSDT Program Under Medicaid*, Chapter 16.

all can significantly impede this process.

The third area of growth is affective development and it includes children's social and emotional behavior. The ability to give and to receive, the capacity for feeling good about oneself and others, to deal with successes and failures are all important parts of social and emotional development.[13]

While experts agree that there are "milestones" in a child's development that can be looked for in areas such as in physical development, other areas such as affective development are more elusive to measure, with standards of what is "normal" varying greatly among cultures and even among families.

The Screening Approach and the Medical Model

Reconciling the complexity of development with the simplicity of screening is enormously difficult. Screening, after all, uses quick, simple procedures and tests capable of a pass or fail interpretation to sort children for follow-up diagnostic tests or care. Screening has been used successfully in the medical arena for years: to find a child with anemia by taking a blood test; a child exposed to tuberculosis by a skin test. Its strength is to detect problems residing in the child that could be found and treated without paying attention to social, environmental or cultural issues, except as these affect the incidence of particular problems. Some developmental problems--vision and hearing deficits, speech impairments caused by physiological malformations and some delays in motor development--lend themselves more readily than others to the screening process.

But even for many problems in the medical arena, screening is too insensitive a barometer. And many developmental problems--especially those involving the complex interaction of physiological, cultural, environmental and emotional factors-- are easy to misjudge in a quick screen. One cannot accurately find the child who is "hyperactive," "disturbed" or "retarded" by the administration of a quick, simple test. These problems call for the clinician to pull together information from many different sources (e.g., physical examination, health history, specific laboratory or other tests, observation of the child, talking with parents) over a period of time to determine whether a sign or symptom is transient and minor, or one of lasting significance.

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[13] The Boston Children's Medical Center and Richard I. Feinbloom, *Child Health Encyclopedia: The Complete Guide for Parents* (Boston, Mass.: Delacorte Press/Seymour Lawrence, 1975), pp. 243-252.

Inappropriate Tests

Because of the complex nature of development it is not surprising that there are no standardized instruments which *alone* satisfactorily find children who have problems. In California, where a special task force was formed to consider ways of screening for developmental problems, the chairman wrote us: "It is true that we have agonized, scrutinized and 'hair pulled' over the developmental screening aspect of our program. We have had an expert subcommittee, sub-subcommittees and consulted every available reference in this area. I might also add that we have been investigating this area on our own in a very intensive research program." But he continued, "I can summarize our findings in a simple statement. It is apparent that there is no reliable developmental screening test. Therefore, we have eliminated a specific developmental screening test for the present."[14]

When a group convened by the National Institute of Mental Health explored the feasibility of a program of mental health screening through EPSDT, they were similarly stymied. They reported that

> Consultant and staff deliberations exposed a wide range of views on the "state of the art" of screening and diagnosis of mental health (emotional) problems in individuals between infancy and twenty-one years of age. Polar opinions were expressed on existing screening and diagnostic instruments, particularly with respect to reliability and validity, sensitivity to language, applicability to cultural minorities, and cost benefit. Strong differences of opinion exist concerning cut-off points or thresholds between normal and abnormal development.[15]

And a team of experts evaluating the EPSDT Research and Demonstration Projects focusing on developmental assessment concluded:

> A chief problem is technological, particularly for screening for emotional problems. There are currently no standardized methods of screening which allow rapid and economic administration, have a relatively high degree of validity and reliability, and are cross-culturally (cross-ethnically) applicable.[16]

Despite these warnings from experts about the uses of standardized tests for developmental screening, many states used standardized tests, including the Denver Developmental Screening Test (DDST), to screen children.[17]

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[14] Letter from Henry R. Shinefield, M.D., Chairman, California Child Health Disability Board, to the Children's Defense Fund, 2 June 1976.

[15] Memorandum from Director, National Institute of Mental Health to Commissioner, Medical Services Administration, concerning NIMH Recommendations to Medical Services Administration concerning the Mental Health Dimensions of Developmental Assessment in the EPSDT Program, 18 August 1975.

[16] Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation*, p. 70.

The DDST tests a broad range of skills and is a comparatively simple test to administer and score. But it is unsuitable for many children. A disproportionate number of children on whom the test was normed were white and from families with professional, managerial and sales backgrounds.[18] Using a test normed on predominantly middle-class, white children to assess the development of poor, Black, Latino, Oriental, Indian and Chicano populations clearly is inappropriate. The cultural bias is evident in some of the items.

> ...one of the language items has the screener checking whether the child says "da-da" to his father or "ma-ma" to his mother correctly during the test, a task totally inappropriate for children from homes where "mama" and "daddy" are not the names assigned to parents or primary caretakers. In another item, the child "passes" by giving the correct "composition" of three items--a spoon, a shoe and a door. One of the specifically "wrong" answers for shoe is "plastic," although synthetics are a component of most shoes. "Wood" is also wrong, although clogs and platforms are commonplace. The first "right" answer is "leather," although only very expensive shoes are made of leather.
>
> Other phrases found on the test--"separates from mother easily," "dresses without supervision," "imitates housework"--are totally based on cultural assumptions and a very specific lifestyle.[19]

Another limitation of the DDST is that it is a reliable and valid instrument for screening children only in a very narrow age range.

> The user of these screening tools needs to keep in mind that...the DDST is not as reliable, valid, sensitive and specific as its authors had hoped. Its use under the age of 30 months should be discouraged since it is of questionable reliability in the first two years of life and misses a high proportion of children identified by technically more superior tests....In the third year of life, it tends to overselect normal children.... The DDST appears to be a fairly satisfactory screening tool at 4-4 1/2 years of age, but even here its concurrent validity is lower than that of other screening tests.[20]

One evaluator stated that the test "yields little more in the nature of reliable information than an interview with the mother, with the inherent distortion of developmental facts by recall."[21]

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[17] "Developmental Assessment in the EPSDT Program: Position Paper" (Washington, D.C.: Medical Services Administration, Social and Rehabilitation Service, U. S. Department of Health, Education and Welfare, 1976), p. 4. (Mimeo.) The Denver Development Screening Test was published in 1968 and developed by William K. Frankenburg and Joseph Dodds. It is for children ages 2 weeks to 6 years and yields scores for performance in four areas: gross motor, fine motor-adaptive, language and personal-social skills. It takes 15-2C minutes to give and can be administered and scored by a technician.

[18] Emmy E. Werner, "Denver Developmental Screening Test," in Oscar Krisen Buros (ed.), *The Seventh Mental Measurements Yearbook* (Highland Park, N.J.: Gryphon Press, 1972), pp. 734-735.

[19] Diane Divoky, "Screening: The Grand Delusion," *Learning, The Magazine for Creative Teaching* (March 1977, p. 31.

[20] Werner, "Denver Developmental Screening Test," p. 736.

How Developmental Assessment is Working in EPSDT

Very little is known about how children are being assessed for developmental problems.[22] All states list a developmental assessment in their EPSDT screening packages, but procedures vary between and within states. Preliminary analysis of an HEW survey of programs shows that, of 38 states reporting, 27 use the Denver Developmental Screening Test alone or with other tests. Four states use specially devised materials, three with the DDST. Seven states report using no materials, but rely instead on the screener's assessment of the child's development; these are generally states where screening is done solely by private practitioners.[23]

Reporting requirements do not single out developmental problems found. Except for the evaluations of the EPSDT Research and Demonstration Projects, few of the studies of EPSDT have looked at this part of the program.[24]

In all of our study states we found generally that screening packages outlined in state manuals for EPSDT included the same procedures for assessing development. All five states called for a physical examination, a health history (with variations in the questions asked) and some kind of specific assessment of the child's abilities as measured against developmental milestones, informally or through the use of a standardized test. Only in Michigan was the DDST given as a routine procedure. In all the other study states, observing the child, talking with parents, or using information from the physical examination or health history was the primary method used for developmental screening, though the DDST was used if indicated.

Our field visits showed, however, that in practice EPSDT was not effectively catching, referring and treating children with developmental problems. Many of the reasons have been discussed in previous chapters:

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[21] Alice E. Moriarty, "Denver Developmental Screening Test," in Buros (ed.), *The Seventh Mental Measurements Yearkbook*, p. 735.

[22] The EPSDT office in the Medical Services Administration has recently conducted a survey of states to find out the status of the developmental assessment component of EPSDT. A summary report will be available Fall 1977.

[23] "Developmental Assessment in the EPSDT Program: Position Paper," p. 4.

[24] In a recent assessment of EPSDT practices under HEW auspices, 18 cities in 6 states were visited in early 1976. In reviewing the screening tests and procedures performed, the reviewers found "no formalized mental health testing or emotional assessment was done." All sites did some kind of developmental assessment through more informal means, though the report does not list the procedures used. (Applied Management Sciences, *Best Practices Report* (Washington, D.C.: Office of Planning, Social and Rehabilitation Service, HEW, May 21, 1976), p. 31.)

- Children went on and off eligibility frequently, making it difficult to provide treatment for developmental problems, many of which require intervention over a period of time.
- Health history forms used in most of our study states were inadequate for getting even the most basic information about a child. Some children had never had a health history taken.
- Providers who had the capacity to provide ongoing and comprehensive care for children--the best kind for dealing with developmental problems--were not widely used in EPSDT programs in many places.
- Programs tailored to the needs of older children and adolescents were lacking. Yet, adolescents confronted a host of health and related problems, different from those of younger children.

In addition to these shortcomings that plagued EPSDT in general, we found several specific ways in which the program was failing to provide settings or services necessary for finding and helping children with developmental problems.

Minimal Parental Involvement

The involvement of parents, or primary caretakers, is important in all services provided to young children, but it is particularly important in assessing and intervening in a child's development.

Because of their ongoing relationship with a child, parents are in the best position to assess their child's development. A number of studies have shown that mothers are very skilled in identifying abnormal development in their children.[25] In addition, parents have

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[25] In one study a simple questionnaire was given to mothers of 603 infants, ages 20-32 weeks. An 80 percent response was obtained. Responding mothers identified more than 90 percent of the children who were subsequently found by a thorough medical examination to have developmental difficulties. (Nicholas Hobbs (Project Director), *The Futures of Children, Categories, Labels and Their Consequences* (Nashville, Tenn.: Vanderbilt University, 1974), p. 94.)

In a project to identify children who might need special education services in New Jersey, a questionnaire directed at the parents of preschool children was used. Parents were asked to indicate concerns for their child in various problem areas and rate the severity of the problem. The number of children identified when screened in the individual programs showed a considerable degree of parent-identification reliability. ("Proceedings from the Child Find Conference," sponsored by the National Coordinating Office for Regional Resource Centers and the National Association of State Directors of Special Education, Washington, D.C., 26-27 March 1975, p. 13.)

A study of the utilization patterns for Crippled Children's Services in Michigan found that in 221 out of 417 cases, mothers who initiated care did so because *they* recognized that their child was developing slowly, rather than as a result of a routine physical examination. (Bureau of Community Health Services, Health Services Administration, *Studies in Handicapping Conditions* (Washington, D.C.: HEW, 1975), p. 4.)

And in Sweden, a health screening program for all 4-year-olds, including a mental health survey, has been instituted. A parent questionnaire is one of the instrucontinuing responsibility to care for their children long after the professionals have performed their function, and they alone determine whether the child gets the needed care. Parents often provide the only continuity among institutions and services, or between screening and treatment. Parental involvement is critical because parents have a major impact on their children's behavior and self image. Therefore, they must be part of any intervention so they can participate constructively in the treatment.

Parents are justifiably cautious about the possible intrusion of caseworkers and caregivers into their family life. To get them to trust and to use EPSDT, parents need to understand why questions are asked, what will happen to the information and what benefits the family will get from the program.

Unfortunately, the EPSDT programs we looked at involved parents only minimally. First, information was given at the wrong time and place. Being told about a program that is going to assess a child's ability to cope, to perform, to develop "normally," at the same time or place as the family is being told whether or not it will get cash assistance, was threatening to many families. To make matters worse, outreach workers who could have explained the program less threateningly usually said nothing about developmental assessment. In Essex County we were told that "the caseworkers don't even know what screening procedures should be included. They are simply told that physicians will do what is indicated." One woman at a Spanish-speaking information center in Genesee County, who works as an interpreter for Spanish-speaking families, did not know anything about the Denver Developmental Screening Test which was used extensively in Michigan, even though she interpreted for parents, screening nurses and social workers.

Parents often were not involved at the time of screening. In South Carolina, for instance, many children were screened without a parent present. In Florence County, one part of the problem was ameliorated by the fact that the caseworker tried to obtain histories during home visits. But while some crucial information may have been obtained from the parent this way, it did not replace the presence of the parent at the time of screening to give information directly to and receive it

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ments used. It asks about the child's level of play and coordination, speech development, independence in dressing, eating, washing, and toileting abilities. An analysis of data from one county for 1969-1970 showed that 93 percent of children considered to need further consultation because of mental problems could have been identified on the basis of the parents' questionnaire and staff observation. (Marsden Wagner, *Sweden's Health-Screening Program for Four-Year-Old Children* (Washington, D.C.: National Institute of Mental Health, 1976), p. 5.)

from the health care professional. In places where screening was done at schools or child care centers, or where children were transported directly from them to screening clinics, parents often could not or were not encouraged to come.

In most cases we found that the rush to get basic procedures done precluded adequate time for informing families about the screening results, what the next steps to take were, or how to manage problems found. At one health center in Suffolk County, New York, which is crowded and understaffed, and where families with appointments often waited 4 to 5 hours, we were told staff members have stopped counseling. "There is too much to do," we were told, "and no privacy to do it in."

People Who Screen the Children and Counsel the Parents

In Chapter 4 we discussed the importance of proper training and supervision for staff who screened children. This is especially important when reviewing development, since the ability and sensitivity of the person doing the screening is even more important than the specific instruments used. Experts agree that,

> "most important, it needs to be kept in mind that a screening tool, even the simplest, is only as good as the sensitivity of its users to the behavior of young children...." Since children of preschool age are frequently shy with strangers, in new settings, and with strange tasks, the skill of the examiners is an especially important issue. In many cases, bilingual competence will be crucial, as will be a thorough knowledge of the expectations of each ethnic group of children.[26]

In a developmental assessment, what is most important is the ability to listen, to observe and to pull together information from the physical exam, health history, direct observation of the child and conversation with the parent. Skills in these areas, therefore, call for trained and experienced practitioners. But traditional medical and nursing training until recently has not focused these skills on child development.

In the places we visited, there was no specific training for personnel doing developmental screening or counseling, except in Michigan, where a three-day course simply instructed people on how to administer the DDST. A nurse who observed the EPSDT program in South Carolina told us she felt it was unlikely that the nurses doing EPSDT screening picked up many developmental problems, or gave the kind of counseling and guidance needed, because of their limited training.

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[26] Werner, "Denver Developmental Screening Test," p. 739, quoted in letter from Dorothy S. Huntington, et al., San Mateo County, California, Task Force on AB 2068 to Henry R. Shinefield, M.D., Chairman, California State Child Advisory Board, 21 June 1974, p. 6.

Good developmental reviews and counseling could hardly take place where practitioners could not communicate with parents and children. Yet at the time of our interview, the South Brookhaven Health Center in Suffolk County, New York, which offered EPSDT services to a predominantly Hispanic community, had no bilingual nurses or doctors. Similarly, the Brentwood Health Center served the second largest Hispanic community in New York state, and at the time of our interview, it employed no Spanish-speaking nurses.

Children Do Not Get the Help They Need

Any kind of screening is only as useful as the help it can bring to children and families who need it. This is particularly true with the sensitive area of development. But unfortunately, there are many problems for which little is known about how best to intervene. Sometimes, helping the parents in managing the problem and being supportive to the child is the best that can be done. Other times a great deal is known about what kinds of intervention will stimulate development. But in our review of EPSDT, we found that needed help was unavailable for several reasons.

In many places the kinds of medical services needed to help children with developmental problems simply did not exist in adequate supply. In rural areas, resources for these problems remained undeveloped. In other places, waiting lists for services were long. As a result, as the Medical Services Administration found, "where there was an indication of no referral for a condition, it was based on the lack of the necessary treatment resource."[27]

Everywhere we visited this was true. In Essex County, New Jersey, we were told

> There is a scarcity of appropriate treatment resources in many areas. Effective, functioning long-term psychiatric and counseling services are extremely limited and becoming more so, especially at lower and middle income levels. Appropriate class placements are becoming more and more difficult to achieve as budget problems interfere in school services. Appropriate medical supervision is sometimes difficult to arrange, although it is much less of a problem than school and counseling services. Day programs for the non-retarded but handicapped child seem to be diminishing.[28]

South Carolina state officials acknowledged they did not know the state's capacity to provide follow-up services for developmental problems. In Mississippi, a private doctor, 90 percent of whose practice was made up of Medicaid patients and a quarter of whose patient load was under 21 years of age, told us that he was opposed to doing developmental assessment because there were too few facilities or psychologists in his county to treat children with problems. Even the program set up in the schools designed specifically to help these children was inadequate. The same doctor described the school's special education program as "just babysitting."

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[27] "Developmental Assessment in the EPSDT Program: Position Paper," p. 5

[28] Letter from Lete Bagdon, Director, Child Development Center, Children's Hospital of Newark, New Jersey, to Children's Defense Fund, 14 June 1976, p. 1.

Reports from the EPSDT Demonstration Projects focusing on developmental assessment identified the shortage of diagnosis and treatment resources as a problem in rural areas and inner cities alike. "Resources available for dealing with developmental and emotional problems identified by the projects are far from adequate. Resources of the projects are the only ones available for dealing with such problems."[29]

News from California and Maine bore the same message:

- Although we now know a great deal about what kinds of extra training and "stimulation" will hasten developmental processes, there currently exist in California very few programs in which this special help may be given to children demonstrating development lags amenable to such advancement.[30]
- We do know that in the area of mental health, needs outnumber existing facilities; therefore, needs often go unmet.[31]

EPSDT does not have to provide all these services itself. In fact, it should make maximum use of a number of other programs designed to provide services to children with developmental problems. These include such federally-funded programs as: Maternal and Child Health, including the Crippled Children's Program; Head Start; Title I of the Elementary and Secondary Education Act; Developmental Disabilities; Education for All Handicapped Children; Mental Health Children's Services; and Title XX of the Social Security Act.[32] These programs all are trying to find some of the same children, identify and treat some of the same developmental problems.

However, little systematic review of the function each program should play has taken place at the federal, state or local levels. Since EPSDT as experienced by most families is not a delivery system, it is dependent on the resources created by other programs to diagnose and treat developmental problems: for example, schools for special education programs; child care and Head Start programs for early stimulation; mental health centers for therapy; health centers, doctors and hospital clinics for medical treatment and physical therapy; and learning resource centers for speech therapy and treatment for hearing and vision problems. While there have been studies and talks about coordination of these programs at the federal level, between the EPSDT Office and the other responsible agencies, little has grown out of these to date.

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[29] Martin, et al. *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975*, p. 81.

[30] Letter from Dorothy S. Huntington, et al., to Henry R. Shinefield, M.D., p. 5.

[31] Letter from Sara Risley, Maine Center for Development, Portland, Maine, to the Children's Defense Fund, 22 June 1976.

[32] For a description of these programs, see Appendix E in this report.

The same is true at state and local levels. There were isolated examples of cooperation, but by and large, coordination of services was nonexistent.[33]

There was no coordination between schools and the EPSDT program in any of our study sites except Genesee County. Most school health officials we interviewed did not have even a working knowledge of the program. A staff member of the Suffolk County Division of Community Mental Health said he had "only a running knowledge" of the EPSDT program; he said that no one from the Division of Social Services or the Health Department had come to talk about either the developmental assessment component of the program or the role the Mental Health Division might play in getting services to children.

The exception to the lack of coordination among agencies was in Flint, Michigan, where an Interagency Health Council had been set up to coordinate health services for school-age children. Even in Flint, however, we were told that children found through EPSDT to need diagnostic services for learning-related problems had to wait half a year for such services through the schools' special education programs.

Limitations on the treatment services covered under state Medicaid plans determined whether or not some of the poor children screened through EPSDT actually got care. We learned, for instance, from a caseworker in Florence County, South Carolina, that therapy for a speech problem was excluded from coverage, although evaluation of a speech problem was not. Staff in the South Carolina state EPSDT office told us that services from private psychologists were excluded from coverage. While it may be preferable to provide such care in the organized setting of a clinic or health center, such exclusions in coverage limited treatment resources available to families. In some places eliminating private providers meant no services at all.

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[33] Agreements were made with 200 Head Start programs in a demonstration project to explore the role of Head Start in providing or arranging for EPSDT services. That contract, however, has recently ended. See Chapter 3 of this report for further discussion.

In some parts of the country, New Orleans and Philadelphia in particular, EPSDT programs and the schools were involved in a cooperative effort using schools to find, screen, refer and follow up children getting EPSDT services.

In Mississippi, psychological evaluations and testing were excluded from coverage except when performed as an inpatient hospital service.[34] Speech therapy was excluded except when provided in a hospital (as an inpatient or outpatient service) or home health agency.[35]

Whether or not services were available also depended on the kinds of personnel a program employed. There were some groups of professionals who were more extensively trained and more interested in child development than others--nurse practitioners, child health aides, physician's assistants. Some--social workers, health aides, counselors--were better trained than others to assist families in dealing with unemployment, poor housing and school problems which contributed to developmental problems. But under Medicaid, the services of such personnel often were not reimbursed. Medicaid law covers reimbursement for services performed by physicians. Beyond this, the law allows states to determine whether to cover services provided in a clinic and which kinds of licensed practitioners can have their services reimbursed. In some states, services by physician's assistants and nurse practitioners were not covered. Those of other professionals so important in counseling and referring families also were not covered. The result is that,

> since social work assistance and social work counseling should play a large role in management of developmental problems, a good deal of our work is not covered by Medicaid at all.[36]

In addition, the majority of children were screened in health department clinics and private physicians' offices--few of which offered support services or employed these personnel who could help with counseling or follow-up care.

Labeling

Screening is a seductive business because it gives the impression of concisely stating something about a child. The fact that the "something" may be wrong, or be only part of the picture, often gets lost.

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[34] *Mississippi Medical Assistance Act, Screening and Diagnostic Manual* (Jackson, Miss.: Blue Cross and Blue Shield of Mississippi, October 1974), p. III-17.

[35] *Mississippi Medical Assistance Act, Screening and Diagnostic Manual*, p. III-17.

[36] Letter from Leta Bagdon, p. 2.

Screening results are often used to label a child "mentally retarded," "learning disabled" or "hyperactive," and with these labels, come a set of assumptions and expectations. The label becomes a shorthand for the whole child. Despite the best intentions of professionals, many programs and institutions--particularly schools--make and justify far-reaching decisions about children on the basis of the labels, not the child's abilities.[37]

Labeling children with problems has had serious and often counterproductive consequences. The stigma for children and their families often outweighs any benefits they may get from special services. But if labeling children who in fact have problems is dangerous, labeling those who do *not* have problems --because of inadequate information or on the basis of inappropriate tests--is worse. The risks of such misclassification are greatest for children in racial or language minority groups, who are socioeconomically disadvantaged, who are "different" in any number of ways or who lack experience taking tests.

Given how stigmatizing labels can be, we were disappointed to find Medicaid policies in our study states that forced screeners to make a diagnosis on the basis of a screen in order to get reimbursed for their services. In Michigan and South Carolina, pediatricians we talked to thought that the only way they could get reimbursed for services, including well-child services, under Medicaid or EPSDT was to make a diagnosis at the conclusion of the visit. Staff at a diagnostic center made the same point. "You have to come up with something wrong to bill," we were told. An administrator of a health center in New York explained that the problem was made worse by the fact that the billing system and the data reporting system were closely tied together. When a bill was submitted for a physical examination or a screen, and a problem was suspected, a preliminary diagnosis was included on the billing form for reporting purposes. As a consequence, children could be falsely diagnosed on the basis of a well-child visit or a screen.

What Do We Conclude?

Clearly, the developmental assessment portion of EPSDT is one of the least understood and least implemented parts of the program. The way EPSDT services are delivered puts further limitations on what the program can do for children. The central question is: Are the potential harms greater than the potential benefits to children of screening and treating them for developmental problems?

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[37] See, for example, Hobbs, *The Futures of Children, Categories, Labels and Their Consequences*; Nicholas Hobbs (General Editor), *Issues in the Classification of Children*, Volumes I and II (Washington, D.C.: Jossey-Bass, 1975); Jane R. Mercer, *Labeling the Mentally Retarded* (Los Angeles, Calif.: University of California Press, 1973); and *Children Out of School in America* (Cambridge, Mass.: The Children's Defense Fund, 1974), particularly Chapter 4.

But it is clear that many children in the EPSDT population are at risk for developmental problems of varying degrees of severity, with very real consequences to them. Problems that are not found and dealt with do not go away. They get worse. And often the children most at risk have no source of care to turn to. Given these dilemmas, is there a role for EPSDT in finding and getting services to children with developmental problems? We think there is.

We advocate that the separate component of screening for developmental problems be removed from the EPSDT program and that the process for finding children with developmental problems be limited to what can be done during a routine, comprehensive pediatric assessment.

It is customary pediatric practice to review a child's development. Taking a health history, including questions about a child's attainment of certain milestones, giving a physical examination including a review of reflexes, vision and hearing, are standard parts of any comprehensive pediatric examination. These procedures focus on the areas of development where there is relatively little disagreement about the typical rate of developmental progress, and they also identify specific problems that can impair development. Furthermore, in the course of performing these routine procedures, the practitioner can observe the child's speech, ability to follow instructions, concentration and responsiveness to people, self-help skills, language development and physical functioning such as coordination and gross and fine motor skills.

In providing children with such comprehensive assessments, EPSDT will fulfill a vital function in finding and getting services to children with certain problems that could critically affect their development. Through this cautious approach there is much less danger of careless implementation which could result in damage to children. On the other hand, it does not throw out the benefits children can derive from assessment of selected and better understood aspects of growth and development.

Many of the recommendations at the end of previous chapters impact on developmental assessment. Below are those recommendations or aspects of them that relate most directly to the assessment, diagnosis and treatment of developmental problems.

Recommendations

1. Title XIX should be amended to replace screening for "physical

and mental defects" with a requirement for states to assure regular, comprehensive health assessments. Federal regulations should not include a separate developmental assessment component, but HEW should define, in collaboration with professionals, administrators and consumer groups, the scope of the developmental review and how it will be carried out within the context of the comprehensive pediatric assessment.

2. In the interim, no standardized tests should be the sole means used to assess children's development, and such tests should be used only when other procedures indicate a test is needed.

3. No standardized tests should ever be used to assess development unless they are found by HEW to meet certain criteria. The criteria should assure that tests are: standardized to norms for age, sex, race, socioeconomic status of the population being assessed; demonstrated valid and reliable; and in a language appropriate to the child. The exact criteria should be established by HEW in consultation with professionals and consumer groups.

4. When identifying for the EPSDT program development plan the gaps in resources and the steps needed to fill them, special attention should be paid to the availability of follow-up diagnosis and treatment services for developmental problems. Local and state task forces (including parents, advocates, administrators and representatives of health programs, day care centers, schools and social service programs) should be set up to coordinate federally-funded and other programs so that all relevant resources in any community are brought to bear on children's developmental problems. At the federal level, EPSDT should enter into agreements with other federal programs to coordinate finding, diagnosing and treating children with developmental problems.

5. Beyond establishing states' responsibility to pay for needed health care following an assessment, federal EPSDT regulations must make explicit that, where special educational and child development services are indicated by a comprehensive assessment, states must at least arrange for such services (as opposed to pay for them).

6. HEW should work with state officials and medical and child development professionals to develop and provide training programs and materials for providers doing comprehensive assessments. Special attention should be given to how to assess development, how to elicit parents' insights about their children's development and how to counsel families. Federal funds for training programs and materials should be made available.

7. State and local administrators should provide all persons doing comprehensive assessements with a list of available diagnosis and treatment resources for developmental

problems in the geographic area in which they practice.

8. In regard to EPSDT, HEW should enforce the provisions in Medicaid regulations and guidelines for consent procedures and safeguards regarding the use of and access to information.[38]

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[38] "A State plan for medical assistance must provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan." (42 U.S.C. §1396a(a)(7). For further detail, see also 45 C.F.R. §205.20(a)(1)(i) and the *Medical Assistance Manual*, Part 5, 5-70-20(E)(5).

Chapter 7

Linking Children To An Ongoing Source of Primary Care: EPSDT's Potential and Performance

Why Is Ongoing Health Care Important?

Having an ongoing source of primary health care means having one place to go when a child needs checkups or shots, when parents need advice about a health matter, or when a child gets sick. It includes having a regular relationship with the people providing the care. Primary care of high quality also includes support services such as outreach, transportation and health education that make it possible for families to use health services appropriately. As we pointed out in our first report on health care for children,[1] the values of putting families in touch with a place where all of their children's basic health needs can be met are striking:

- Evaluations of Neighborhood Health Centers and Children and Youth Projects, all of which offer such care in one place, have shown marked reductions in infant mortality, prematurity and illness.[2]
- In communities where access to comprehensive care had been improved, there have been substantial reductions in hospital admissions and in the inappropriate use of hospital emergency rooms.[3]

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[1] *Doctors and Dollars Are Not Enough*, (Washington, D.C.: Children's Defense Fund, 1976), pp. 12-13 and 71-72.

[2] Maternal and Child Health Services, *Promoting the Health of Mothers and Children*, Fiscal Year, 1972 (Washington, D.C.: HEW, Federal Stock No. 1730-0029, 1973); Karen Davis, "A Decade of Policy Developments in Providing Health Care for Low Income Families" (Washington, D.C.: The Brookings Institution, July 1975), pp. 47-48. (Mimeo.)

[3] Louis I. Hochheister, Kenneth Woodward and Evan Charney, "Effect of the Neighborhood Health Center on the Use of the Pediatric Emergency Departments in Rochester, N.Y." *New England Journal of Medicine*, Vol. 285 (July 1971); Robert M. Hollister, Bernard M. Kramer, Seymour S. Bellin, (eds.), *Neighborhood Health Centers* (Lexington, Mass.: Lexington Books, D.C. Heath and Co., 1974); "Mile Square Health Center, Inc., 1973: Year of Transition," (Chicago, Ill.: Mile Square Health Center, 1974).

- In one city where families were randomly assigned to a comprehensive care program, there was a significant increase in receipt of preventive services and a significant *reduction* in laboratory costs, prescription medications, hospitalizations, operations and illness visits.[4]

- Studies show that when care is continuous, a physician can detect complications at an earlier stage because of familiarity with the patient.[5] Conversely, doctors caring for patients only in specialty clinics were not aware of from 28 to 98 percent of abnormal laboratory findings which might have affected their handling of the patients.[6]

- Patients who have a regular source of care are more likely to keep appointments and, if they cannot keep their appointments, they are more likely to notify the clinic that they will not be there.[7]

- Patients with a regular doctor or medical team are more diligent about following instructions concerning medication.[8]

- Mothers have been found to give more complete information about their children for medical histories and to report health problems sooner if they have a regular source of care.[9]

EPSDT, too, provides data which suggest that families are more apt to use health services that can help when their children are sick *and* well, rather than those that give only screening or only treatment. A survey of 247 randomly selected mothers enrolled in a comprehensive care clinic in an EPSDT Research and Demonstration Project found that the availability of care for sick children and treatment for problems found in screening helped to attract families to the clinic for screening, as well as for other services.[10]

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[4] L.S. Robertson, et al., "Toward Changing the Medical Care System: Report of an Experiment," in Robert Haggerty, "The Boundaries of Health Care " *Pharos of Alpha Omega Alpha*, Vol. 35 (July 1972), pp. 106-11.

[5] Hugh Tilson, "Stability of Physician Employment in Neighborhood Health Centers," *Medicare Care*, Vol. 11 (September-October 1973), p. 393.

[6] Charles R. Kelley and Joseph J. Mamlin, "Ambulatory Medical Care Qualities: Determination by a Diagnostic Outcome," *Journal of the American Medical Association*, Vol. 227 (March 1974), p. 1155.

[7] Joel Alpert, "Broken Appointments," *Pediatrics* (July 1964), p. 127

[8] Marshall Becker, "Predicting and Enhancing Compliance in a C and Y Project," Final Report under Grant MC-R-240081-01-0, (Washington, D.C.: Maternal and Child Health Service, HEW); and Evan Charney, et al., "How Well Do Patients Take Oral Penicillin? Collaborative Study in Private Practice," *Pediatrics*, Vol. 40 (August 1967), pp. 188-195.

[9] Marshall Becker, Robert Drachman and John P. Kirscht, "Continuity of Pediatrician: New Support for an Old Shibboleth," *The New Journal of Pediatrics*, Vol. 84 (April 1974), pp. 599-605.

[10] Fred Fiedler and Harold D. Dickson, *The Barrio Comprehensive Health Care Center, Final Evaluation Report* (San Antonio,

Data from four EPSDT Research and Demonstration projects underscore the need for linking children to ongoing care. From 68.2 to 86.5 percent of all problems found in screening were chronic and required care to be provided regularly over a long period of time.[11] (See Table 1.) The majority of these children, then, needed to be under regular, medical supervision.

While providing comprehensive, continuous care makes sense in human and cost terms, such services are not generally available to people in this country. Many communities lack the most basic health resources, much less comprehensive programs.[12] Even where there are adequate health resources, poor families relying on Medicaid and EPSDT, and dependent on public systems of delivery, find it difficult or impossible to get comprehensive, ongoing care. Consider the example of a young mother on AFDC.

> Assuming that she...is well motivated...she will seek prenatal care as soon as she finds that she may be pregnant. She seeks this care from her local health department clinic. When the time comes for her to deliver the baby, she is transferred (theoretically with her records but actually most likely not) to a public hospital. There she encounters a new set of documents and personnel for delivery of the baby. Before discharge, the baby will be examined by a pediatrician who will never see the child again. Now this...

Texas: Health Services Research Institute, University of Texas Health Science Center, November 1, 1975, p. 8. In addition, data from another evaluation suggest that EPSDT is more effective when screening and case management are part of a health program of comprehensive care, than when provided separately. An analysis of the EPSDT programs in eighteen localities in six states found:

> Providers who offered screening and case management services in a comprehensive setting showed an increased probability that treatment would be provided in a timely manner upon referral over other organization types....

(Applied Management Sciences, *Best Practices Report* (Washington, D.C.: Office of Planning, Research and Evaluation, Social and Rehabilitation Service, HEW, May 21, 1976), p. 12.)

[11] Harry W. Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974-March 1975* (San Antonio, Texas: Health Services Research Institute, University of Texas Health Science Center, 1975), p. 60.

[12] More than 45 million people live in areas where the health care delivery system is nonexistent or inadequate. (Macy Foundation Commission, *Physicians for the Future* (New York: Josiah Macy Foundation, 1976), p. 6.) About 120 rural counties have no physicians. (Macy Foundation Commission, *Physicians for the Future*, p. 6) There are 1,670 officially designated "health scarcity" areas--areas where health and related services are not available to major portions of the population. (Interview with staff in Program Office for National Health Service Corps, Bureau of Community Health Services, HEW, 4 March 1977.) In other places, there are services but not the ideal kind--not providers who can fill all children's basic health care needs in one place. When there are inadequate primary care providers for the general population, Medicaid recipients usually have a harder time finding care.

young woman will take her baby to a well-child clinic operated again by her health department but at a different place from where she received her prenatal care and at a different time. After several such visits to the well-child clinic, the baby may become ill. When the mother takes the baby to the clinic where the doctors and nurses have been providing care, she is informed that she cannot obtain care there any longer because the child is sick. She is advised to take the child to a physician near her home who is paid by the welfare department. This new physician establishes still another record for the baby and provides care in his or her office. If the child becomes sick enough to require hospitalization, the physician tells the mother that (s)he is not able to admit her child to the hospital where (s)he practices because she is on welfare and she must take the baby back to the public hospital.[13]

This mother may choose not to make all these visits, all these different appointments, travel to all these different places, spend her time, energy and car fare figuring out this fragmented system. For a poor mother who does not have a regular source of health care, and who does have other serious problems to cope with, being shunted from one clinic to another, depending on what her child needs, makes the difference between using health services--including EPSDT--and going without them. As one outreach worker put it:

Table 1

PERCENTAGE OF SCREENING PROBLEMS DECLARED CHRONIC AND ACUTE, BY PROJECT AND AGE

Project and Age	Number	Percent Chronic	Percent Acute
All Ages:			
Barrio[1]	1,639	80.0	20.0
Contra Costa[2]	110	68.2	31.8
Cuba[3]	52	86.5	13.5
Ages 0-4:			
Barrio	516	70.0	30.0
Contra Costa	33	45.4	54.6
Cuba	1	100.0	0.0
Ages 5-11:			
Barrio	735	85.2	14.8
Contra Costa	53	73.6	26.4
Cuba	50	88.0	12.0
Ages 12 and Above:			
Barrio	147	85.0	15.0
Contra Costa	24	87.5	12.5
Cuba	1	0.0	100.0

[1] Texas

[2] California

[3] New Mexico

Source: Martin, et al., *EPSDT Demonstration Projects: An Interim Evaluation, April 1974 - March 1975*, p. 60.

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[13] Nathan Glazer, "Paradoxes of Health Care," *The Public Interest* (Winter 1971), pp. 62-77.

> That's not a stupid mother! That's not a mother who hates her kids! That's somebody who says to herself "Why am I doing all of this?"...She's got all these burdens plus the fact that her husband may be losing his job because the economy is being managed by keeping unemployment at a containable figure, which means a tightening of the belt for most people but strangulation for the poor, who go first. With all of these things, is this lady going to horse around town for three straight weeks in order to do something called EPSDT? No, she's not going to do that at all.[14]

EPSDT's Potential

The goal of linking children to ongoing primary health care was never an explicitly stated purpose of the EPSDT program. In fact, the HEW Program Analysis Group (that recommended the initiative in child health which resulted in EPSDT) advocated a screening rather than a comprehensive care program.[15] The resulting program was relatively narrow in scope. Its charge was to find children, screen them for particular problems and get them to a source of diagnosis and treatment for those problems discovered in screening.

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[14] "Public Health Currents," Vol. 15, No. 3 (Columbus, Ohio: Ross Laboratories, August 1975), p. 4.

[15] The Program Analysis Group took the position that because of the absense of hard data on the effectiveness of various kinds of child health programs and services, it was not possible to encourage one kind of arrangement over another. "As a result of the lack of data on effectiveness of existing maternal and child health programs," wrote the co-chairman of the Group three years later, "decisions on possible expansion of these programs were bound to depend almost entirely on 'professional judgment.'" (Joseph S. Wholey, "The Absence of Program Evaluation as an Obstacle to Effective Public Expenditure Policy: A Case Study of Child Health Care Programs" (Washington, D.C.: The Urban Institute, 1969), pp. 458-459.) Choosing not to make such judgments, and further choosing not to solicit judgments from consumers of care, the Program Analysis Group decided instead to "structure the problem (around) some reasonable objectives toward which progress could be measured ...." (Wholey, p. 461.)

As is often true, objectives toward which progress can be easily measured may not have been the most important or best objectives. Thus, one of the major reasons for the initial choice of a screening program over a comprehensive care program, and for not focusing directly on the opportunity to use screening as a basis for getting children into comprehensive care, was a reluctance to make judgments in areas where hard data was unavailable, or where non-quantifiable considerations played an important part. Furthermore, the Program Analysis Group was unwilling to include in its planning fundamental changes in the way child health services were being delivered. While it recommended the establishment of demonstration projects to test the feasibility, costs and effectiveness of new ways of providing children with comprehensive health services and new ways of training and using physician assistants, it based its recommendations for the new screening program on its finding that "with existing, or anticipated, numbers of physicians, comprehensive child health care will not be feasible on a wide scale...." (Wholey, p. 461.) Had the energy that went into implementing the limited screening program been instead devoted to the development of more effective programs of comprehensive care, including the improved utilization of a wide variety of health personnel, we might have a very different set of services today. (Wholey, pp. 459-461.)

But even though linking children to ongoing health care was not an articulated goal of EPSDT, the program *can* accomplish this in two ways. First, when EPSDT programs are successful in getting children to come in for screening, they can then refer families to sources of continuing, primary health care. Second, screening and treatment themselves can be provided by sources of ongoing care. Screening, therefore, becomes the first of many services children receive from the doctor or health center with which they were put in touch through EPSDT. In fact, provisions in EPSDT and Medicaid statutes and regulations encourage this. The Medicaid statute and regulations call for maximum use of existing resources,[16] including comprehensive care providers. And the Medicaid statute provides that recipients should be able to choose which participating provider to go to.[17] The use of health centers or solo doctors to provide screening, diagnosis and treatment gives parents an opportunity to link their children to a wider range of services in the process of having them screened or treated.

Indeed, in its Forward Plan for EPSDT for 1976, HEW stressed the potential of EPSDT for linking children to sources of comprehensive care:

> Linking a Medicaid family with a specific clinic or physician, where possible, can help avoid unnecessary and costly emergency room care for those conditions which do not require emergency care. EPSDT should not become yet another unrelated piece of an already fragmented health care system; it should be an opportunity to integrate all Medicaid services for eligible individuals under 21.[18]

Similarly, the EPSDT manual prepared by the American Academy of Pediatrics recommended that:

> ...Ideally, each child should receive all of the screening services he requires as an integral part of continuing preventive health maintenance and illness care. The ideal setting is in a physician's office or clinic which provides comprehensive health care for children

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[16] The "maximum use" provision in the law (42 U.S.C. §1396a(a)(11)(A) says that the state Medicaid plan must provide for cooperative agreements with state agencies responsible for administering health services and vocational rehabilitation services. (See also 42 U.S.C. §1396a(a)(22)(C) and 45 C.F.R. §251.10(a)(1) and (12).) The regulations also require that Medicaid agencies assure the maximum use of existing screening, diagnostic and treatment services provided by other public and voluntary agencies (45 C.F.R. §249.10(a)(3)(iii)). Both the statute and the regulations require agreements between Medicaid agencies and Title V (Maternal and Child Health) grantees which will provide for the use of care and services available under the Title V plan or projects which are included in the state plan for medical assistance. (42 U.S.C. §1396a(11)(B) and 45 C.F.R. §251.10(a)(2).)

[17] 42 U.S.C. §1396a(a)(23) and 45 C.F.R. §249.20.

[18] Medical Services Administration, "EPSDT Program: Forward Plan, 1976" (Washington, D.C.: HEW), p. 4. (Undated mimeo.)

> regardless of their economic situation or their source of payment.[19]

But in practice, EPSDT rarely links children to sources of routine health care.

The EPSDT Connection — Why Isn't It Happening?

Despite the evidence in favor of using comprehensive health providers to deliver EPSDT services, in most places the connection is not being made. An analysis of EPSDT practices in six states with well-developed programs concluded that:

> Providers who could supply integrated services in part, such as HMO's, pediatricians, family/general practitioners, primary care group practices or clinics, and organized outpatient departments within hospitals accounted for less than 10 percent of the screening...More importantly, none of the states surveyed had emphasized the provision of screening, diagnosis, and treatment in a comprehensive care setting.[20]

Health Departments Are Used For Screening

In 1975, 25 states screened children primarily in health department clinics which traditionally have provided a few selected preventive services such as immunizations, well-baby or specialty care and very limited, if any, care for sick children.[21] Some 58.8 percent of all screenings through EPSDT in 1975 were performed in health departments. (See Table 2.)

Three of our five study states provided screening primarily through health departments, which performed 57.5 percent of all the screenings in our study states. As a result, children screened in these three states had to return to a specialty clinic or find other sources of health care if they needed diagnosis, treatment or other care. (See Table 3.)

Generally, the decision to limit screening to health departments stemmed from the fact that health departments already existed in each county and were a ready delivery system to implement the

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[19] William K. Frankenburg and A. Frederick North, *A Guide to Screening for the EPSDT Program Under Medicaid*, prepared by the American Academy of Pediatrics (Washington, D.C.: Social and Rehabilitation Service, HEW, June 1974), p. 29.

[20] Applied Management Sciences, *Barrier Assessment Report: Assessment of EPSDT Practices and Costs* (Washington, D.C.: Office of Planning, Research and Evaluation, Social and Rehabilitation Service, HEW (SRS-500-75-0019), November 15, 1975), p. 25.

[21] In fiscal 1976, nineteen states used primarily health departments for screening, accounting for 44.2 percent of all screenings. (See Medical Services Administration, "Working Data" (Washington, D.C.: Social and Rehabilitation Service, HEW, 1977.)

Table 2

NUMBER AND PERCENT OF SCREENINGS PERFORMED DURING FISCAL 1975, BY TYPE OF SCREENING PROVIDER USED IN STATES[1]

Type of Screening Provider	Number	Percent
Health Departments Only	867,015	58.8
Mixed Provider Groups[2]	607,000	41.2
Total	1,474,015	100.0

[1] States using only Health Departments as screening providers are identified by asterisks following the state name in Table 3 of Appendix F.

[2] Mixed provider group states also do some screening through Health Departments. Thus the number of screenings by Health Departments is underestimated above.

Source: Medical Services Administration, "Health Providers Utilized by the States for the EPSDT Program," (Washington, D.C.: Social and Rehabilitation Service, HEW, 1975) (Mimeo.); and Medical Services Administration, "Fiscal Year 1975 National Statistical Summary of EPSDT" (Washington, D.C.: Social and Rehabilitation Service, HEW, 1975). (Mimeo.)

Table 3

NUMBER AND PERCENT OF ALL SCREENINGS PERFORMED DURING FISCAL 1975 IN CDF STUDY STATES, BY TYPE OF SCREENING PROVIDER USED

Type of Screening Provider	Number	Percent
Health Departments Only:		
Michigan	124,270	
Mississippi	36,818	
South Carolina	30,138	
Subtotal	191,226	57.5
Mixed Provider Groups[1]:		
New Jersey	14,211	
New York	126,856	
Subtotal	141,067	42.5
Total	332,293	100.0

[1] Mixed provider group states also do some screening through Health Departments. Thus the total number of screenings performed in Health Departments is underestimated above.

Source: See Appendix F, Table 3.

screening part of EPSDT. The effect, however, was to limit the access children had to a broader range of services that would better fill their total health needs. Even where more comprehensive health care providers existed, they were effectively excluded from delivering preventive care under Medicaid. In some states, children were routinely referred to health departments for screening even if they had a regular doctor. And even in states where policy allowed private doctors to be reimbursed by Medicaid for performing checkups (the equivalent of a screening), many doctors did not know this was possible. For example, one state Medicaid administrator told us that, in fact, physicians could be reimbursed for providing well-child care by checking the diagnostic code number on the billing form for a physi-

Table 4

SCREENING RATES FOR CHILDREN ELIGIBLE FOR EPSDT AS OF THE CLOSE OF FISCAL 1975, BY TYPE OF SCREENING PROVIDER USED IN THE STATES[1]

Type of Screening Provider	Eligible	Screenings	Screenings Per 100 Eligibles
Health Departments Only	4,260,744	867,015	20.3
Mixed Provider Groups[2]	5,584,765	607,000	10.9
Total	9,982,999	1,474,015	14.8

[1] States using only Health Departments as screening providers are identified by asterisks following the state name in Appendix F, Table 3.

[2] Mixed provider group states also do some screening through Health Departments.

Source: Calculated from data given in Appendix F, Table 3.

cal examination. But this fact was not readily apparent to physicians and, the administrator admitted, "We don't go around with loud horns talking about that."

In those states where a range of providers (including comprehensive ones) were used to screen children under EPSDT, assuming children got to screening, their chances of being linked to ongoing sources of care would have been greater. But in fiscal 1975, fewer children and a smaller proportion of eligible children were screened in states using mixed providers than in states using only health departments. In our study states, too, those using health departments screened more children and a higher percentage of eligible children than states using a variety of health care providers. (See Tables 4 and 5.)

Table 5

SCREENING RATES FOR CHILDREN ELIGIBLE FOR EPSDT AS OF THE CLOSE OF FISCAL 1975 IN CDF STUDY STATES, BY TYPE OF SCREENING PROVIDER USED

Type of Screening Provider	Eligibles	Screenings	Screeings Per 100 Eligibles
Health Departments Only:			
Michigan	530,004	124,270	23.4
Mississippi	151,563	36,818	24.3
South Carolina	110,483	30,138	27.3
Combined	792,050	191,226	24.1
Mixed Provider Groups[1]:			
New Jersey	376,544	14,211	3.8
New York	1,169,119	126,856	10.9
Combined	1,545,663	141,067	9.1
Five-State Rate:	2,337,713	332,293	14.2

[1] Mixed provider group states also do some screening thrugh Health Departments.

Source: Calculated from data given in Appendix F, Table 3.

Additional Barriers Faced by Comprehensive Providers

Aside from limiting screening to health departments, states made a variety of other decisions restricting children's opportunity to go to comprehensive providers of primary care. For instance, coverage of services provided by clinics or other organized providers of outpatient services is *optional*[22] under Medicaid. According to federal regulations, state Medicaid programs must reimburse outpatient services *only* when provided by a hospital or by physicians. Nationwide, eleven states and territories (excluding Arizona which has no Medicaid program) have elected *not* to reimburse clinic services under Medicaid,[23] a decision which excluded many community providers that could offer a range of services to eligible children.

Among the states that covered clinic services, some used criteria for certification that were so narrow that they inappropriately excluded certain kinds of clinics from participating in Medicaid. For instance, a survey conducted by HEW in 1975 found that eleven states recognized only public or community mental health clinics or outpatient psychiatric facilities as clinics; two recognized only public health department clinics; and five required that clinics be affiliated with a hospital or a medical school.[24]

Sometimes the standards set for clinic certification excluded providers of a wide range of services because they applied criteria designed to measure competence in providing elaborate or specialized medical care. As one expert on Medicaid put it:

> New kinds of providers such as community-sponsored clinics, neighborhood health centers, and day-care center health programs face serious obstacles in getting paid by Medicaid because planning certificates, recordkeeping requirements, and reimbursement schedules are designed for traditional medical

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[22] While in some states the clinic itself is not reimbursed for Medicaid services, *individual* physicians in that clinic can be reimbursed. Under these arrangements, only the expenses for the physician's services are reimbursable; none of the related costs for the clinic's administrative or other services can be reimbursed. (42 U.S.C. §1396d(a)(9) and 45 C.F.R. §249.10(b)(9).)

[23] For states covering clinic services under Medicaid, see Table 2 in the Introduction to this report.

[24] George P. Tolbert, *Third Party Payor Assessment* (Final Report on the Third Party Payor Questionnaire) (Washington, D.C.: Division of Health Services Financing, Bureau of Community Health Services, Health Services Administration, Public Health Service, HEW, March 20, 1975), p. 5

> practice. The very devices designed to regulate the traditional providers--but which generally fail to do so--become the barriers to more innovative practice. Some regulation of new providers is undoubtedly necessary, but much more could be done to encourage their development through technical assistance and reimbursement designed for their needs.[25]

In other instances the problem was not with inappropriate criteria but with the subjective or discriminatory fashion with which the criteria were applied. In New Jersey, for example, we were told by a state official that the method for assessing the qualifications of a potential provider was to "eyeball the services--staff, and facilities." The room for errors in judgment or for discrimination in such a process is great.

States also limited the participation of comprehensive care providers in Medicaid by deciding not to reimburse for the services of certain types of personnel--for example, nurse practitioners, physician's assistants, or child health associates--under Medicaid. Only 21 states reimbursed services of these and other "physician extenders."[26] In these states, licensing laws frequently limited the circumstances under which such practitioners could provide care. Some states, for instance, elected to reimburse for the services of physician extenders only when a physician was present. Such policies excluded many of the community-based clinics providing primary care to families in rural and urban areas, where a full-time physician was not always present but where physician extenders were supervised by formal protocols and periodic reviews of their work (and sometimes by direct telephone access to a physician).

Even when a variety of providers were allowed to participate in the EPSDT program, Medicaid reimbursement policies often made it infeasible and unattractive for some excellent sources of care to participate. Rates for most EPSDT services are computed on the basis of *reasonable charges.*[27] States negotiate rates with providers for these services, but the fee levels must encourage a sufficient number of providers to participate in Medicaid so services are as available to Medicaid patients as to others in the community.[28] This provision, however, has never been enforced. States have chosen a wide variety of methods for setting rates, but few of them have produced incentives for providers to participate --particularly those providers that offer a wide range of health support services as well as medical services. A federal study conducted in 1974 revealed:

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[25] Rand E. Rosenblatt, "Lurching Toward the Abyss: Medicaid Cutbacks and Health Care Inflation, Part II," Health Law Project, *Library Bulletin* #317 (January 1976), p. 6.

[26] This information is taken from an informal survey done in 1975. James Simpson, *Reimbursement to Physicians' Assistants and Nurse Practitioners Under Medicaid* (Los Angeles, California: National Health Law Program, November 25, 1975). (Mimeo.) While there are no other available published surveys, several reports are expected this summer, from the National Rural Center in Washington, D.C.; the Appalachian Regional Commission in Washington, D.C.; and the Medical Services Administration in HEW.

- Reasonable charge reimbursements for physicians' services in many states were so low that they covered only a small portion of the actual cost of each visit to these comprehensive care centers;
- 47 states' flat or negotiated rates did not cover the actual cost of providing comprehensive care;
- Only 2 states provided payment on a cost-related, all inclusive basis.[29]

In some places, reimbursement rates set specifically for EPSDT screening services were particularly unattractive to providers who could offer children more than EPSDT services. While the average cost of screening in 1975 was $21 per child, we found,

- in Florida comprehensive care providers received $6.50 for screening a child;
- in Oklahoma private physicians and comprehensive neighborhood health centers received $9.00 for a screen.[30]

Families Are Not Counseled to Seek Comprehensive Care

Finally, what children and families are told when they are first informed about EPSDT services or when they come in for screening and treatment often affected whether the child was linked to a physician or clinic that could provide a full range of child health services.

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[27] 45 C.F.R. §250.30(b)(3)(i). The "reasonable charge" for providing a service is the lowest of the following: actual billed charge for the service; customary charge (the amount normally charged a majority of patients over the last calendar year); the area's prevailing charge (charge which falls within the range of charges most frequently used in a locality for a particular medical service or procedure).

[28] 45 C.F.R. §250.30(a)(6).

[29] While the flat or negotiated rate paid to providers of comprehensive care may cover specific medical services, it does not cover the cost of outreach, access and other support services. Tolbert, *Third Party Payor Assessment*, p.11

[30] National figures come from the Task Force on Human Resources, Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," *Working Papers on Major Budget and Program Issues in Selected Health Programs* (Washington, D.C.: Committee on the Budget, U.S. House of Representatives, 10 December 1976), p. 129. Florida's and Oklahoma's rates are from the Medical Services Administration, "Rates of Reimbursement for Screening Services through EPSDT, by State," "Working Data" (Social and Rehabilitation Service, HEW, February 1977).

For instance, how the choice of which provider to use for screening (in the states that allowed a variety) and follow-up services (all states allowed a variety) was described to a family influenced profoundly where the family decided to go. Medicaid mothers in Suffolk County told us the choices were not presented clearly. Some parents whose children had a regular doctor did not understand that their child could be screened by their physician. They either reluctantly agreed to take their children to the clinic (which offered more limited services) or chose not to use EPSDT services at all. Instead of being referred to comprehensive care providers, most children in Suffolk County who did not have regular sources of care were referred to health center "satellite clinics," where very limited preventive and treatment services were offered.

In all of our study sites we found that wherever parents brought their children for EPSDT, they were rarely told that these services were only part of the total health care their children needed or could get under Medicaid. This was a special problem for children whose conditions found in screening needed the care of a specialist. We were told by one member of a team studying EPSDT in Michigan that

> Many parents who are referred to a specialist through EPSDT are not told that it is important to continue going to their regular doctor. They view that referral to a doctor as just that, and do not make the distinction between what they continue to need from a general practitioner and the special trip their child has made for a specific problem.

We were told, too, by people who referred parents to places for further treatment that they generally made referrals to the places they knew best. They gave little if any consideration to which provider would be most suited to giving primary care to the child over the long haul.

The result of these decisions and omissions was that despite the potential of EPSDT, too few children were linked to a source of comprehensive, continuing care. The cost in terms of program efficiency and effectiveness was high. So was the cost in human terms.

Recommendations

Particularly strong federal leadership is needed to shift the design of EPSDT programs so that children are put in touch with a regular source of health care through an assessment, diagnosis or treatment.

1. The Congress should establish immediately a program to develop needed resources for providing primary care services. Federal funds and technical assistance must be available to assist organized providers of limited services (e.g., screening programs) to expand their services so that children can receive assessments, routine treatment and other health services from the same provider. In addition, federal funds and assistance must be available to help communities develop *new* resources for providing general medical and specialty care where, due to scarcity, currently children are unable to be assessed and treated promptly.

2. Title XIX should be amended to make the coverage of services provided in primary care clinics, which meet states' certification criteria, mandatory rather than optional. In addition, primary care health services, when provided by physician extenders, nurses and paraprofessionals licensed in accordance with state law and working in organized clinic settings, should be reimbursed as clinic services. HEW should assist states in devising state codes governing licensing, certification and reimbursement for the use of physician extenders, nurses, and paraprofessionals to assess and provide routine care to children. Sufficient staff in HEW should be assigned to assist state and county administrators and clinic providers in arranging for reimbursement of services provided by such personnel in EPSDT programs.

3. Federal regulations should require states to identify and offer reasonable contracts to all qualified providers. To assist states, the federal EPSDT office should compile and make available to states a list of federally-funded, primary care health programs in each state. States should inventory other qualified health organizations. A person in each state's EPSDT office should be designated to help interested qualified providers negotiate state Medicaid licensing and certification processes and work out agreeable contractual terms with the state or local Medicaid agency.

In addition, HEW should enforce vigorously the requirement in Medicaid that states establish reimbursement rates sufficient to assure that recipients have access to services to the same extent as to others in the community.

4. Based on recommendations devised by HEW, states must establish standards for provider certification which are appropriate to EPSDT. Standards should be set for two kinds of providers:

a. comprehensive care providers, which assume responsibility for complete EPSDT services, as well as ongoing primary care services for children; and

b. providers of assessment, capable of performing complete assessments and with established referral relationships and case management arrangements (either carried out by own staff or by the state Medicaid agency) to assure needed follow-up care.

5. Members of state and local medical and pediatric societies should assist state and local EPSDT administrators to design administrative and reporting arrangements which are acceptable to providers. They should also mount efforts to get more providers to participate in the EPSDT program.

6. HEW should monitor state programs closely to make sure that states comply with federal law requiring that recipients have a choice among providers.

7. States should train personnel who perform EPSDT outreach and assessments to put families in touch with a regular source of care. For children who do not have a regular doctor or clinic, special efforts should be made to refer them to a comprehensive care provider for assessment. Such providers should be encouraged to explain to families the importance of having their children checked at intervals appropriate to age, should discuss the kinds of symptoms the child might have which would warrant a phone call to the provider when the child is sick, and should encourage the parent to bring the child back for subsequent care, as needed. In addition, providers should be strongly encouraged to continue to see a child, even if he or she loses Medicaid eligibility.

Appendix A

How We Chose Our Study Sites

Since we wanted to study how effectively EPSDT was providing poor children with health services rather than to evaluate the program *per se*, we looked at EPSDT programs that had been in place for some time, where a relatively large number of children had been receiving services for at least a year, and where there was as much data as existed anywhere about the programs' effectiveness.

First, we discussed EPSDT with a number of people who knew it well nationally. These included:

Harvey Block, Bokonon Systems, Inc., Washington, D.C. (responsible for an EPSDT evaluation contract);

Patricia Butler, National Health Law Program, Los Angeles, California (an attorney assisting in a number of EPSDT lawsuits);

Harold Dickson, Health Services Research Institute, San Antonio, Texas (responsible for several EPSDT evaluation contracts);

Anne-Marie Foltz, Health Policy Project, Yale University School of Medicine, New Haven, Connecticut (who was working on a study of the impact of EPSDT in two New England states and is the author of a number of papers and articles on EPSDT and other child health programs);

Robert Sims, Boone-Young Associates, New York, New York (who had a contract to evaluate Head Start's demonstration program with EPSDT); and

Chapin Wilson, Department of Health, Education and Welfare, Washington, D.C. (Supervisor, Monitoring Section, Division of EPSDT).

On the basis of their recommendations, we collected a variety of information on selected state programs. We reviewed EPSDT penalty assessments, state manuals for EPSDT, other official memoranda describing how the program was supposed to work, state Medicaid plans, statistics on EPSDT services, and special descriptive and analytical reports. We also collected immunization data for these states and reviewed state statutes relating to health screening for school-age and preschool children.

Through this process, we identified a dozen states with relatively developed programs. We then looked more closely at each of them to select a smaller number to visit that varied in geographic and demographic characteristics and also in how the Medicaid and EPSDT programs were designed. We wanted a mixture of factors represented in our sites: geographic variation, urban and rural populations, areas with adequate medical resources, areas with insufficient resources and ethnic and racial mixes. We also wanted to study programs representing a variety of ways EPSDT could be administered, for example: variations in the agency or agencies--welfare departments, health departments, or some combination of both--administering EPSDT at the state and county levels; variations in what the state's Medicaid plan covered; and variations in aspects of the EPSDT program itself (such as provisions for outreach, transportation, kinds of providers, the role of local welfare and health departments in carrying out the program, the degree of integration with other services offered through other health, education and child care programs, and levels of consumer involvement).

On the basis of the information we gathered about these issues and conversations with people who knew the state and county programs, we selected five states and one county within each state. In Michigan we chose Genesee County; in Mississippi, Oktibbeha County; in New Jersey, Essex County; in New York, Suffolk County; and in South Carolina, Florence County.

We visited each of these places and talked with parents, program administrators, physicians, dentists, nurses, state and county Medicaid agency personnel, staff at neighborhood clinics, hospitals, outpatient departments, welfare agencies, schools, Head Start and other child care centers and other community organizations. (For a complete list of the people with whom we spoke during our study, see Appendix B.) We reviewed state laws, regulations, guidelines and policies regarding Medicaid and EPSDT, and we examined closely local practices in each of our study sites.

Genesee County is in the southeastern part of Michigan, right next to Detroit County. In 1974, about half of its 444,300 population was 24 years of age or younger. The per capita income in Genesee County--$3,320--put it in the middle of the range represented by our study sites.[1] Next to Suffolk County it had the largest percentage of people (almost 50 percent) with incomes over $10,000 per year. However, 21.5 percent had incomes below $5,000 per year.

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[1] Statistical data on our study sites comes from Michael Barone, Grant Ujifusa and Douglas Matthews, *The Almanac of American Politics* (New York: E. P. Dutton and Company, 1975); *Health Care in the South: A Statistical Profile* (Atlanta, Ga.: Southern Regional Council, 1974); and Health Resources Administration, Public Health Service, U. S. Department of Health, Education and Welfare, "Selected Measures of Health Manpower, Facilities and Education, by Health Areas" (Washington, D.C.: HRA, 1975). (Computer printouts.)

The major city in Genesee County, where we did most of our interviewing, is Flint, often described as the nation's largest company town because 60 percent of metropolitan Flint wage earners work in the city's five major General Motors plants. While blue-collar workers outnumber management, those who have profited from the auto industry have not left: Flint has its plush residential sections and city benefactors.

Both Essex County in New Jersey and Suffolk County in New York had substantially more medical resources than Genesee County, but Florence County, South Carolina and Oktibbeha County, Mississippi had many fewer. There were no medical schools or dental schools in Genesee County, but there were four nursing schools, seven general hospitals (four of which had organized outpatient departments), and some 500 doctors (a ratio of 873 persons per doctor). (If the more than 100 osteopaths were included in these calculations, the total number of physicians in the county would be 628, making the physician-patient ratio 1:707.) In addition, there were 183 dentists in the county, or one dentist for every 2,428 people.[2]

Michigan was known for its strong health department-based EPSDT program. It was also a state which collected more detailed data on the program than almost any other state. State officials recommended we study Genesee County because of the high performance ratings given to its EPSDT program. This, coupled with the fact Flint was a mid-western, industrial, middle-class, medium-sized city, led us to select it as one of our sites.

Oktibbeha County is largely "hill country" in the north central part of Mississippi not far from the Alabama border. Families here were poor: over half of them had incomes under $3,000 a year. There were no major cities in the county though it was the home of the largest state university in Mississippi. Of all our sites, Oktibbeha County had the fewest medical resources (both in absolute numbers and in proportion to population) for its 28,800 residents (one-third of whom were black): twelve doctors (only one of whom was black), six

[2] Doctor- and dentist-patient ratios in each of our study sites can be compared to national averages. In 1973 there was one physician for every 562 people and one dentist for every 2,088 people. (Health Resources Administration, Public Health Service, U. S. Department of Health, Education and Welfare, *Health: United States 1975* (Washington, D.C.: HRA 76-1232), pp. 103 and 106.)

dentists, and one optometrist. This meant there was only one physician in the county for every 2,400 people and one dentist for every 4,800 people. Distance and lack of public transportation made even these resources inaccessible to many people.

Of all our study sites, Oktibbeha County had the highest infant mortality rate--50 for every 1,000 live births compared to the national average of 16.7 per 1,000. Oktibbeha County also had the lowest per capita income--under $2,000.

We were interested in going to Mississippi because it was one of the first states to implement the EPSDT program. The problems Oktibbeha County residents faced--poverty, the lack of medical resources and difficulty in getting to the ones that did exist--typified those confronting many who live in rural areas of the country.

In Essex County, New Jersey, almost all of the 930,000 people lived in the predominantly black city of Newark or its surrounding suburbs. We spent most of our time in Newark, which had many of the problems common in central cities: a fleeing middle class, an eroded tax base, too few jobs, and too many poor, unemployed people. The unemployment rate was high, and even the largest employer, Prudential Insurance, was quietly and rapidly moving to the suburbs. Those who were left--mostly poorer Blacks, Italians and Eastern Europeans--were there because they could not get out.

Nonetheless, of our study sites, Essex County had the second highest per capita income level: $3,738. Forty-two percent of the people lived on incomes over $10,000; 30 percent lived on incomes under $5,000.

The resources for health care in Essex County were more abundant (in absolute numbers) than in any other county we visited: eighteen general hospitals, over 2,000 doctors, over 700 dentists, a medical school, a dental school, many nursing schools and several colleges and universities. Its physician-patient ratio (1:421) was the most favorable of all our other study sites. There was one dentist for every 1,290 people.

While the EPSDT program in New Jersey was not exceptional, we wanted to study it because New Jersey used a variety of providers --neighborhood health centers, hospital outpatient departments, day care centers, private doctors and health department clinics--to provide services. It had a data system that separated EPSDT from the rest of Medicaid, and it had an active consumer constituency based in Newark which was concerned about the program.

Suffolk County is on the eastern end of Long Island. To some, Suffolk

County conjures up the image of affluent Manhattanites escaping to suburban homes on the Atlantic coast. But that was only one kind of life style in Suffolk County. Blue-collar white and black families from New York City came to what used to be potato fields in Suffolk County in search of more space, single-family dwellings, jobs in the aircraft manufacturing business and security. The population of Suffolk County grew 69 percent during the 1960s. While most of the 1,125,000 population was white, small cities and towns such as Wyandanch and North Brookhaven had sizeable black populations. In addition, an influx of Hispanic people, many of whom were poor, created large, Spanish-speaking communities in Patchogue and Brentwood.

Of all our sites, Suffolk County was the most affluent: 57.4 percent of the families had incomes of $10,000 or more. Yet it also had the largest AFDC population of all our study sites. Suffolk County had the lowest infant mortality rate of our study sites: 20 per 1,000 live births. Second only to Essex County in the health resources available, it had nine nursing schools, fourteen general hospitals (three of which had organized outpatient departments), over 1,500 doctors, over 700 dentists and almost 6,000 nurses. In Suffolk County, there were 738 people for every doctor and 1,571 people for every dentist.

New York designed its EPSDT program with the goal of introducing children to ongoing, comprehensive health care. Suffolk County was recommended by state officials as one of the places where this approach had been developed most fully. As in New Jersey, a variety of providers were used, and there was more cooperation between private physicians and the program than was common in our other sites.

South Carolina was reported to have one of the most highly developed and carefully managed EPSDT programs in the country. Officials in HEW's federal and regional offices felt that since nearly all of its counties used primarily county health departments for screening, there would be a high degree of uniformity and we could generalize our findings to the state as a whole.

We went to Florence County, a rural section in the northeastern part of the state where tobacco farming and textile mills provided the major source of employment. About one-third of the population of 89,600 was black, and 27.2 percent of the population lived below the federal poverty line. In Florence, the major city in the county, about 20 percent of the homes had no plumbing. It was a poor area, though not as poor as Oktibbeha County, Mississippi. While the medical resources were far fewer in number than those available in Essex, Genesee and Suffolk counties, there were more than in Oktibbeha County. Some 90 physicians (only several of whom were black) served the county. There was one physician for every 996 people and one dentist for every 3,090 people. Of the three general hospitals, only one had an organized outpatient department. While there were no medical or dental schools, there were two nursing schools and one college. Florence County had the second highest infant mortality rate of the places we visited: 29 per 1,000 live births. As in Oktibbeha County, Mississippi, distance and lack of transportation kept many people away from the care that was available.

Appendix B

People Interviewed By CDF Staff For This Report

The following are the people who gave CDF staff their time and provided us with information about EPSDT when we visited each of our five study sites. The titles and affiliations of these people were accurate at the time of our visit, although some may have changed by the time this report went to press. We also interviewed parents and children on Medicaid and eligible for EPSDT in each community but, to preserve their anonymity, we have not included their names here.

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Appendix C

EPSDT Lawsuits

This is a summary of lawsuits filed as of October 1976. The information is taken primarily from reports on each case prepared by attorneys for the plaintiffs as background for a national conference on EPSDT, sponsored by the Legal Services Corporation, held in Miami, Florida, October 1976.

State	Name of Case	Date Filed	Contact Person
California	*Telles v. California Health and Welfare Agency,* No. C73-0967 WHO (N.D. Cal.) Consent order entered, 9 *Clearinghouse Review* 197 (1975)	6/11/73	Steve Fleisher Department of Consumer Affairs 1020 N Street, Room A-602 Sacramento, CA 95814 (916) 445-5126
Colorado	*Lavato, et al. v. Shea, et al.,* No. C-4790 (D. Colo.) Opinion reported at CCH Pov. L. Rptr. ¶21,831 (Oct. 29, 1975)	2/73	Bill Benjamin Legal Aid Society of Metropolitan Denver 912 Broadway Denver, COL 80203 (303) 837-1313
Connecticut	*Connecticut Union of Welfare Employees v. White,* 55 F.R.D. 481 (D. Conn. 1972); 357 F.Supp. 1378 (1973)	4/72	Edward Mattison Technical Assistant Project 495 Orange Street New Haven, CT 06511 (203) 336-3851 Marilyn Katz Fairfield County Legal Services 285 Park Avenue Bridgeport, CT 06611 (203) 336-3851

State	Name of Case	Date Filed	Contact Person
Illinois	*Illinois Welfare Rights Organization v. Edelman*, No. 73C1398 (N.D. Ill.)	6/1/73	Robert Berger, James Weill Legal Assistance Foundation of Chicago 343 S. Dearborn Chicago, ILL 60604 (312) 341-1020
Indiana	*Bond v. Stanton*, 372 F.Supp. 872 (D.Ind. 1974), aff'd 504 F.2d 1246 (7th Cir. 1974), cert. den., 420 U.S. 984 (1975)	7/23/73	Ivan E. Bodensteiner Valparaiso University School of Law Valparaiso, IND 46383 (219) 464-5433
Kentucky	*Louisville Welfare Storefront Counseling, Inc., v. Dawson, et al.*, No. C-75-0163L(B) (W.D. Ky.)	5/75	Larry Elswit Legal Aid Society of Louisville, Inc. 317 S. Fifth Street Louisville, KY 40202 (606) 584-1254
Maine	*Brooks v. Smith*, 356 A.2d 723 (Maine Supreme Judicial Court, 1976)	9/4/74	Susan Calkins Pine Tree Legal Assistance, Inc. 178 Middle Street Portland, ME 04111 (207) 774-8211
Massachusetts	*Vega v. Bloomsburgh*, Civ. Ac. No. 74-5877-T (D. Mass.)	12/30/74	Peter Anderson Mass. Law Reform Institute 2 Park Square Boston, MA 02116 (617) 482-0890
			Lee D. Flournoy Western Mass. Legal Services 41 Eagle Street North Adams, MA 01247 (413) 664-4531
			Kenneth Neiman Western Mass. Legal Services 247 Cabot Street Holyoke, MA 01040 (413) 536-2420
Michigan	*Dominguez, et al. v. Milliken*, Civ. Ac. No. G-198-72-CA (W.D. Mich.) Opinion reported at CCH Medicaire-Medicaid Guide ¶26,632 (Jan. 3, 1973); CCH Medicare-Medicaid	6/30/72	Sue Sattler, Terry Adams Michigan Legal Services 900 Michigan Building 220 Bagley Detroit, MI 48226 (313) 964-4130

State	Name of Case	Date Filed	Contact Person
Michigan (Cont'd)	Guide ¶26,633 (Mar. 19, 1973)		Chris Campbell Greater Lansing Legal Aid 302 Community Services Center 300 N. Washington Avenue Lansing, MI 48933 (517) 485-5411
Minnesota	*Minnesota Recipients Alliance v. Likins*, No. 4-75-422 (D. Minn.)	8/18/75	Rebecca Knittle Development Disabilities Advocacy Project 501 Park Avenue Minneapolis, MN 55415 (612) 338-0968
New York	*Woodruff v. Lavine*, 399 F.Supp. 1008 (S.D. N.Y. 1975); 417 F.Supp. 824 (1976)	12/73	Michael A. O'Connor Community Action for Legal Services, Inc. 335 Broadway New York, NY 10013 (212) 966-6600
Ohio	*Morland v. Gilligan*, No. C-74-53 (N.D. Ohio) Consent order entered, CCH Pov. L. Rptr. ¶19,566 (July 18, 1974)	1/21/74	Edward R. Stege, Jr. Legal Aid Society of Cleveland 2108 Payne Avenue, Rm. 728 Cleveland, OH 44114 (216) 861-6242
Pennsylvania	*Philadelphia Welfare Rights Organization v. Shapp*, No. 73-290 (E.D. Pa.) Consent orders entered, March 15, 1974 and January 19, 1976	2/13/73	Steve Gold Community Legal Services 313 S. Juniper Street Philadelphia, PA 19107 (215) 893-5382
Vermont	*Vermont Low Income Advocacy Council, Inc. v. Davis*, No. 74-49 (D. Vt.)	2/4/74	Michael Lipson Vermont Legal Aid, Inc. 150 Cherry Street P. O. Box 562 Burlington, VT 05404 (802) 863-2871
Wisconsin	*Wisconsin Welfare Rights Organization v. Newgent*, No. 75-C-102 (E.D. Wis.)	2/28/75	Larry Albrecht Milwaukee Legal Services, Inc. 1006 S. Sixteenth Street Milwaukee, WIS 53204 (414) 645-9022

Appendix D

Views of Organizations and Agencies On Developmental Assessment in EPSDT

The following are positions or statements about the developmental assessment component of EPSDT from several national organizations or agencies. They are the groups' public views and may not represent the views of all individuals connected with them. There are other local organizations or agencies that have taken positions on developmental assessment, but we were unable to get their statements in time for inclusion here. As a result, the groups below may not represent all points of view in the debate on developmental assessment.

The American Academy of Child Psychiatry recently voted to "support the goals of the EPSDT developmental screening programs ... with the provision that close attention be paid to the care with which EPSDT programs carry out the humane, personal, and privacy requirements." More specifically, the Academy is concerned about inadequacies such as the use of culturally-biased screening instruments, premature labeling, insufficient attention paid to treatment of problems found, and problems of confidentiality. "The committee recommends that, with regard to developmental disorders, the construction of methods of triage and seeking and utilizing treatment resources rather than engaging in a search for an ultimate screening instrument, definitive psychiatric diagnoses, and/or definitive psychiatric treatment when useful therapeutic endeavors can be made at other levels."

For more information, contact: Harold Boverman, Chairman, Committee on EPSDT, American Academy of Child Psychiatry, 1800 R Street, N.W., Suite 904, Washington, D.C. 20009.

The American Association of Psychiatric Services for Children, under contract with HEW to make specific recommendations regarding the implementation of the developmental assessment component of the EPSDT program, concluded that, among other things: the EPSDT mandate should be expanded to apply to all children; the orientation of the program should be away from a screening process and toward a review process which identifies a child's strengths as well as weaknesses; no single instrument for developmental assessment should be mandated nationally; after two years no standardized procedure should be used in the program until it has been approved pursuant to regulations adopted by the Secretary, and parents must be maximally involved in the review process.

For more information, contact:
Debora Kramer, Executive Director, American Association of Psychiatric Services for Children, Inc., 1701 18th Street, N.W., Washington, D.C. 20009.

The American Orthopsychiatric Association, under contract with HEW to prepare a guide for use in the implementation of the EPSDT developmental assessment component, concluded that it is premature to prepare such a guide because of the large number of obstacles to developing a program in the best interests of the children the program serves. Culturally-biased tests, the lack of available treatment resources, fragmented services, problems of confidentiality, changing eligibility of children, and problems with the state of the art of prediction through screening and diagnosis of children from a range of cultures were among the problems cited. The Association proposed that projects be developed to test and plan ways to overcome these obstacles.

For more information, contact:
Marion Langer, Executive Director, American Orthopsychiatric Association, Inc., 1775 Broadway, New York, N.Y. 10019

The Consortium Concerned with the Developmentally Disabled advocates the evaluation of existing instruments for EPSDT screening by a group of consumers (parents) and professionals from relevant disciplines. The Consortium stated that there are available screening instruments of merit from which a model screening instrument for use in the EPSDT program could be developed.

For more information, contact:
Paul Marchand, Chairman, Consortium Concerned with the Developmentally Disabled, 1522 K Street, N.W., Suite 516, Washington, D.C. 20005

The National Association for Mental Health, Inc. recommended that the President convene a panel of professional consultants to examine the mental health screening component of EPSDT to determine whether this screening component is being used to label children and whether any of the screening results are computerized. If either of these things are happening, the Association would strongly oppose continuation of the mental health screening component of the program.

For more information, contact:
Elizabeth Metcalf, Committee on Service Delivery, National Association for Mental Health, Inc., 1800 North Kent Street, Arlington, Virginia 22209.

The National Institute of Mental Health, in fulfilling an agreement with the Medical Services Administration in HEW to make recommendations regarding the mental health component of EPSDT, stated that all children should be screened for mental health problems but that it is premature to establish a uniform, nationwide mental health screening, diagnosis and treatment program for children from birth through age 21 because of the controversy over the appropriate and responsible use of screening and diagnostic instruments. NIMH called for study of the impact and community acceptance of currently used standardized tests; study of the use of natural raters (parents, guardians, peers) in screening; removal of noncompliance with the mental health dimension of EPSDT developmental assessment activities as a factor in assessment of states for noncompliance with program requirements; and consultation at the state level with professional organizations and interested consumer organizations.

For more information, contact:
Stephen Hersh, Chief, Center for Studies of Child and Family Mental Health, National Institute of Mental Health, Parklawn Building, Room 15004, 5600 Fishers Lane, Rockville, Maryland 20852.

Other Federal Programs Providing Services For Children With Developmental Problems

A number of federally-financed programs other than EPSDT provide or pay for services for children with developmental problems. While the scope of services provided, the population served, the agency or institutions involved and the conditions covered under each program differ, these programs all are engaged in related tasks.

Crippled Children's Services

The Crippled Children's Program (Title V of the Social Security Act; administered by the Office of Maternal and Child Health, Bureau of Community Health Services, Health Services Administration, HEW) makes grants to state health departments to extend and improve, especially in rural areas and in areas suffering from economic distress, medical and related services to crippled children and children suffering from conditions that lead to crippling. Each state plan covers different crippling conditions.

Developmental Disabilities Program

The Developmental Disabilities Program (Title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, as amended; administered by the Office of Developmental Disabilities, Office of Human Development, HEW) has as its purpose to improve and coordinate the provision of services to persons with developmental disabilities attributable to mental retardation, cerebral palsy, epilepsy, or autism, which originate before the age of 18, constitute a substantial handicap and are expected to continue indefinitely. The program also establishes a system for the advocacy and protection of rights for persons with developmental disabilities. Grants are given to states to assist in developing and implementing a comprehensive plan for identifying and meeting the needs of the developmentally disabled, for training personnel, providing technical assistance in the establishment of services and facilities, developing new and improved techniques for providing services and developing a system to protect and advocate the rights of developmentally disabled persons.

Education for All Handicapped Children

Under the Education for All Handicapped Children Act (Education for All Handicapped Children Act of 1975; administered by the Bureau of Education for the Handicapped, Office of Education, HEW), funds are dispensed to school districts through state departments of education to pay a portion of the cost of providing educational and related services to handicapped children at the preschool, elementary and secondary school levels. Children who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled or other health impaired children who require special education and related services are eligible. Important substantive and procedural rights and protections for children and their parents are built into the law.

Head Start

The purpose of the Head Start Program (Community Services Act of 1974, Title V, Part A; administered by the Office of Child Development, Office of Human Development, HEW) is to provide comprehensive health, educational, nutritional, social and other services to preschool, economically disadvantaged children and their families. Funds are provided by the federal government to about 1,200 local projects across the country. Approximately 12 percent of the total enrollment nationwide are handicapped children. Two hundred Head Start programs participated in a two-year special project to explore the interrelationship of Head Start with EPSDT.

Maternal and Child Health Services

The purpose of the Maternal and Child Health Services program (Title V of the Social Security Act; administered by the Office of Maternal and Child Health, Bureau of Community Health Services, Health Services Administration, HEW) is to extend and improve (especially in rural areas and poor areas) medical and related services to reduce infant mortality and improve the health of mothers and children. In areas with high concentrations of low-income families, projects are to be established to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing, and to help "promote the health" of children and youth of school and preschool age. The funds, which go to state health departments, support, among other things: well-child, maternity, pediatric and mental retardation clinics; public health nurses; screening, diagnosis and treatment services; immunization and school health programs; intensive care units for newborns; comprehensive care for children and youth; maternal and infant care; dental care; and family planning services.

Mental Health-Children's Services

The Mental Health-Children's Services legislation (Community Mental Health Centers Amendments of 1975, Part A, Section 203(e); administered by the Division of Mental Health Service Programs, National Institute of Mental Health, HEW) provides grants to community mental health centers, affiliates of them, or certain nonprofit agencies to provide a range of mental health services for children and their families residing in a service area.

Title I, Elementary and Secondary Education Act

Title I (of the Elementary and Secondary Education Act of 1965, as amended; administered by the Office of Education, HEW) funds go to state departments of education to provide financial assistance to school systems which have high concentrations of low-income children residing within their districts. The purpose of Title I is to provide additional help to children with special needs resulting from poverty, neglect, handicapping conditions and cultural or economic deprivations. Title I funds can also be used to provide auxillary services such as food, health and dental services to such needy children.

Title XX, Social Security Act

Title XX of the Social Security Act (Social Services Amendments of 1974; administered by the Public Services Administration, Office of Human Development, HEW) provides reimbursement to states for services provided by and to various state agencies, and service contractors, usually through state departments of welfare or departments of human services. The purpose of the program is to furnish services to low-income families to achieve or maintain self-support and/or self-sufficiency, to prevent or remedy neglect, abuse or exploitation of children, to rehabilitate or reunite families, to prevent or reduce inappropriate institutional care by providing for community-based care or other less intensive forms of care, and to secure referral or institutional care when appropriate. State plans include support services which include but are not limited to child care services, protective services for children and adults, family planning for all AFDC recipients, services related to the management and maintenance of the home, transportation services, information, referral, and counseling services. Medical care may be included if it is an integral but subordinate part of a service.

Appendix F

National EPSDT Data

Explanation

SRS publishes quarterly and annually a summary of the EPSDT data submitted by the 50 states and several United States territories and possessions. The accuracy of the data reported to SRS is unverified and in 1975 and 1976 several returns were incomplete. Two states, Illinois and Indiana, did not report the number of children eligible for EPSDT as of the end of both fiscal years, so SRS estimated that number for them. Indiana did not report the number of children screened and, as a result, no useful performance statistics can be computed for Indiana, although we included Indiana in our tables. We did not include Arizona in any of our tables because it did not participate in Medicaid and therefore does not have an EPSDT program. In all cases, we used the data as it was reported to SRS.

The count of screened children referred for specific conditions was not always reported by every state. Some states reported some items and not others. In several cases, we could not tell whether a state meant to report zero referrals for a condition or if it meant to indicate that the actual number of referrals was unknown. Because using zero values for states where the information might have been unknown would have biased our estimates of prevalence rates downward, we have *always* excluded from the prevalence rate estimates any state that reported zero referrals for that condition. If any state really found no children with a specified condition out of the thousands screened, then our procedure would have produced prevalence estimates that were *slightly* biased upward. We doubt, however, that any state in fact tested thousands of children and found no referable conditions. Instead, we suspect that some states either did not test for the conditions or did not report those found. This problem primarily affected the reports of referrals for lead paint poisoning, where only 34 states reported counts of referrals. For all other specific conditions, at least 47 of the 52 states and territories reporting at all reported counts for each condition.

Definitions of Categories on Tables 1, 2 and 3

Some of the concepts used in reporting must be defined here, since there is not sufficient room on our computer-produced tables to give detailed definitions.

Eligibles. This is the number of children actually reported by the state as eligible for EPSDT as of the end of the fiscal year. In its published summaries, SRS inflated this number by a factor to account for turnover (1.3 in fiscal 1975 and 1.2 in fiscal 1976) and always reported a higher number than we present. The SRS inflation was unfortunate, since in their reports it appeared that the number of children eligible for EPSDT was slowly falling. That appearance was, however, due solely to their change in the factor used to inflate the eligibility counts. In fact, the actual number of eligible children was slowly rising.

Screenings. This is the number of screenings that states reported. Since a child may have been screened more than once (either because the child fell into an age group where the state screened more than once per year, or because a single complete inventory of tests was administered and reported on two different days), the number of screenings was always somewhat higher than the number of children screened.

Identified Conditions Referred. This includes the columns labeled "VISUAL," "AUDITORY," "DENTAL," and "LEAD P"--for lead poisoning. These were counts of the number of *conditions* referred, and not necessarily the number of *children* who had such conditions. The same child may have been referred twice for the same condition. However, it is not likely that such double counting occurred often enough to damage our estimates seriously. We found no such duplications in our review of county-level data, and most state forms we reviewed prevented double reporting of individual conditions. However, a child may well be reported more than once for different conditions. Thus, the "SUBTOTAL" of these conditions included a substantial amount of double counting, and should *not* be used as a "percentage of screened children referred." All that we can be certain of is that the true percentage of children screened who were referred for the identified conditions was greater than the greatest ratio shown for any of the individual conditions and less than the ratio shown for the "SUBTOTAL."

"OTHER" Conditions Referred. States and localities tested for and reported conditions other than the four mentioned above. This column reports the number of other conditions that were also referred. This column is *not* comparable from state to state because of the wide range in the conditions that were included. Further, it contains double counts of children both within itself and with other reported conditions. Finally, Georgia, in fiscal 1975, reported 23 referred conditions for lead paint poisoning, but *no* referred conditions overall. Since this was clearly an error, we did not use data from Georgia in any national estimates (except the lead paint poisoning count) for that fiscal year.

The Total Conditions. This is the sum of the individually identified referred conditions and the "OTHER" conditions. It is a highly duplicative count.

The Cumulative Screened From 1972 to Date, Including the Current Fiscal Year. This figure is the total of reported *screenings* from the origin of EPSDT to date. It includes some duplicate screenings of the same child. Using our rough performance standard (i.e., that a state should perform approximately 66.7 screenings per 100 eligible children), the correct level for the *cumulative* screenings per 100 children eligible (assuming eligibility counts were roughly constant) was 266.7 in fiscal 1975 and 333.3 in fiscal 1976. No state approached these performance targets.

SRS also showed national totals on its reports for 1975 and 1976. The totals for 1976 were accurate. The totals given for fiscal 1975 were riddled with arithmetic and transcription errors. This caused us considerable difficulty, because when the totals published by SRS did not balance, we could not always tell whether the totals or the detail were in error. The size of the possible errors, however, was quite small (less than 1 part in 1,000 for the totals), except in one instance. The 1975 figure for the cumulative screenings to date was too low by exactly 100,000 screenings. We corrected this figure by working backwards from the 1976 totals. In this case, the 1975 totals and not the detail were wrong.

CDF Table 1

Table 1 shows the national totals for fiscal 1975 and fiscal 1976. The top line of each year's summary gives the national total count. The second line gives the count of states and territories which reported non-zero values for each item. (There were a total of 52 states and territories which reported, excluding Arizona which has no program.) The third line of each summary gives the number reported per 100 eligible children. For example, the first figure on the third line, the number of screenings per 100 eligible children, is our performance characteristic. If we compare the screenings per 100 eligibles in 1975 (which was 15.0) to our standard of 66.7, we find that the effectiveness ratio (the percent of our standard attained) was 22.5 percent in 1975. For 1976, the effectiveness ratio had risen to 25.8 percent.

The fourth line of the national totals shows the number reported per 100 screenings. For example, the first figure in that line is the number of referrals for visual acuity problems per 100 screenings. The last line of national data for each year is the percentage of conditions referred which was accounted for by each specific condition. These are not percentages of either children screened or of screenings, since each screening may produce more than one referred condition.

For all ratio figures, such as the number of referrals for visual acuity conditions per 100 screenings, the national estimates exclude entirely any state or territory that reported either component of the ratio as zero. Thus, a state that reported either the number of referrals for visual acuity conditions as zero or that reported the number of screenings as zero (Indiana is an example of the latter) was not counted *at all* (for either the numerator or the denominator) in calculating the national ratio. National estimates were based only on states and territories that reported non-zero values for both components of the ratio.

CDF Table 2

Table 2 shows those states and territories that reported, ranked from the highest to lowest values (the highest value is ranked as 1) for each of several performance measures. The rankings shown are for:

- Screenings per 100 eligibles, 1976;
- Visual conditions referred per 100 screenings;
- Auditory conditions referred per 100 screenings;
- Dental conditions referred per 100 screenings;
- Lead poisoning conditions referred per 100 screenings;
- Percent of conditions referred for other than specific identified conditions; and
- Total conditions referred per 100 screenings.

CDF Table 3

This is a listing, in alphabetical order by name of state, of all the data for each of the 52 reporting states and territories. The format is similar to that used for the national totals, except that a "count of states reporting" line is eliminated, and the ranking of each figure reported is shown just below each figure. The ranking shows the position of the state for the reported year for the specific figure, when all states are ranked on that figure. (A ranking of 1 is given to the highest value for a figure.) States which reported zero are not ranked, and the corresponding ranking shows as a zero.

The two-digit numbers in front of each state's name on the listing are the sequence numbers for the states in the SRS reports.

An asterisk appears after the name of each state reported by HEW in 1975 and 1976 as relying primarily on county health departments to provide screening.[1] All other states (those without asterisks) used a variety of providers for screening. The data from Table 3 in this appendix is the basis for Tables 1-4 in Chapter 7 of the report.

Conclusions about states' performance based on their rankings must be made with a great deal of caution. Screening and referral is not a simple proposition of "the more, the better." In evaluating the adequacy of states' performance, actual rates should be compared to expected or appropriate rates for screening and referral. However, appropriate rates for referral in particular are difficult to define because there are so few national data from which to derive norms. Even if there were, many factors in various localities can cause deviations from these norms. While we realize the limits in interpreting such data, we have included rankings so that readers can begin to make some comparisons among states. We suggest that rates and rankings be compared to the few reference points which exist. For example, see Appendix H for how many children *should* be screened and Table 3 in Chapter 4 for the national prevalence of selected conditions in children.

The state with the most referrals, ranked number 1, may not be doing the best job. It is possible that states over-refer (that is, refer children who do not in fact have the reported problems) because of failures in the quality of testing or because of pressures from treatment providers. Such a state, ranked first in the nation, would obviously be performing less well than states with more modest referral rates.

Nor would the state ranked number 1 necessarily be performing adequately. If the state ranked number 1 fell far below appropriate rates, it would not be performing adequately even though it was doing better than other states.

In the case of these EPSDT data, since actual screening and referral rates for fiscal 1975 and 1976 generally fell below appropriate rates, the rankings in this table do reflect relative performance among states compared to standard rates.

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[1] The information for 1975 is derived from Medical Services Administration, "Health Providers Utilized by the States for the EPSDT Program " (Washington, D.C.: Social and Rehabilitation Services, HEW, 1975). (Mimeo.)

The information for 1976 comes from the preliminary results of an HEW survey. Medical Services Administration, "Working Data" (Washington, D.C.: HEW, 1977.)

TABLE 1

NATIONAL EPSDT TOTALS

NATIONAL EPSDT TOTALS, FISCAL YEAR 1979

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	9982999	1474015	119934	35689	351697	11919	519239	486324	1005563	3152156
STATE RETURNS	52	51	47	47	47	37	48	47	48	51
PER 100 ELIGIBLE		15.0	1.4	0.4	4.0	0.1	5.8	5.6	11.2	32.0
PER 100 SCREENED			8.7	2.6	25.4	0.9	36.9	35.2	71.6	
% OF CONDITIONS			11.9	3.5	35.0	1.3	51.6	48.4	100.0	

NATIONAL EPSDT TOTALS, FISCAL YEAR 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	10280144	1743396	135650	40012	413359	8246	597267	545602	1142869	4895552
STATE RETURNS	52	51	47	47	48	34	48	48	48	51
PER 100 ELIGIBLE		17.2	1.5	0.5	4.4	0.1	6.4	5.8	12.2	48.2
PER 100 SCREENED			8.5	2.5	25.0	0.6	36.2	33.1	69.2	
% OF CONDITIONS			12.1	3.6	36.2	1.0	52.3	47.7	100.0	

TABLE 2

STATE EPSDT PERFORMANCE CRITERIA, STATES LISTED IN RANK ORDER.

RANK	SCREENINGS PER 100 ELIGIBLES STATE NAME	1975 VALUE
1	NORTH DAKOTA	51.0
2	COLORADO	44.2
3	OKLAHOMA	41.0
4	NEVADA	40.2
5	LOUISIANA	40.0
6	TEXAS	39.0
7	TENNESSEE	37.4
8	IDAHO	36.9
9	OREGON	36.8
10	IOWA	36.7
11	ALASKA	33.7
12	KANSAS	31.4
13	ARKANSAS	30.8
14	NEW MEXICO	30.5
15	NEBRASKA	27.4
16	SOUTH CAROLINA	27.3
17	FLORIDA	27.0
18	NORTH CAROLINA	26.5
19	MISSISSIPPI	24.3
20	MONTANA	23.6
21	MICHIGAN	23.4
22	ALABAMA	23.3
23	CONNECTICUT	22.5
24	VIRGINIA	22.1
25	PENNSYLVANIA	21.6
26	DELAWARE	21.4
27	WEST VIRGINIA	21.1
28	WASHINGTON	19.2
29	MAINE	16.4
30	UTAH	15.5
31	MISSOURI	15.3
32	NEW HAMPSHIRE	14.3
33	HAWAII	13.5
34	WISCONSIN	13.2
35	KENTUCKY	12.6
36	SOUTH DAKOTA	12.6
37	NEW YORK	10.9
38	MINNESOTA	10.7
39	MASSACHUSETTS	10.1
40	OHIO	8.5
41	VIRGIN ISLANDS	8.1
42	VERMONT	7.9
43	GEORGIA	7.5
44	PUERTO RICO	7.4
45	ILLINOIS	7.4
46	DISTRICT OF COLUMBIA	7.2
47	RHODE ISLAND	6.4
48	MARYLAND	4.7
49	WYOMING	4.4
50	NEW JERSEY	3.8
51	CALIFORNIA	1.6

RANK	SCREENINGS PER 100 ELIGIBLES STATE NAME	1976 VALUE
1	COLORADO	58.8
2	FLORIDA	50.4
3	IDAHO	49.1
4	GEORGIA	45.7
5	TENNESSEE	45.6
6	NEVADA	42.1
7	ALASKA	40.9
8	OREGON	40.9
9	TEXAS	38.9
10	NEBRASKA	38.2
11	IOWA	38.0
12	MISSISSIPPI	37.0
13	DELAWARE	35.9
14	WYOMING	33.4
15	WEST VIRGINIA	32.5
16	CONNECTICUT	31.3
17	NEW MEXICO	30.7
18	NORTH CAROLINA	30.4
19	ALABAMA	28.7
20	PENNSYLVANIA	28.6
21	WASHINGTON	27.8
22	ARKANSAS	27.8
23	VERMONT	25.6
24	SOUTH CAROLINA	25.0
25	VIRGINIA	24.4
26	VIRGIN ISLANDS	24.3
27	KANSAS	23.5
28	UTAH	23.5
29	LOUISIANA	23.0
30	MICHIGAN	21.7
31	KENTUCKY	21.4
32	MAINE	21.0
33	OKLAHOMA	19.7
34	HAWAII	17.4
35	OHIO	16.8
36	MISSOURI	16.1
37	NEW YORK	14.2
38	NEW HAMPSHIRE	13.5
39	SOUTH DAKOTA	13.0
40	NEW JERSEY	12.5
41	MONTANA	11.6
42	RHODE ISLAND	10.6
43	ILLINOIS	8.3
44	DISTRICT OF COLUMBIA	7.8
45	MINNESOTA	7.5
46	WISCONSIN	7.2
47	NORTH DAKOTA	6.9
48	MASSACHUSETTS	6.4
49	MARYLAND	4.9
50	CALIFORNIA	2.5
51	PUERTO RICO	2.4

STATE EPSDT PERFORMANCE CRITERIA, STATES LISTED IN RANK ORDER.

RANK	VISUAL CONDITIONS PER 100 SCREENED STATE NAME	1975 VALUE
1	NORTH DAKOTA	31.2
2	OKLAHOMA	25.2
3	TENNESSEE	18.9
4	OREGON	16.4
5	ALASKA	15.7
6	WISCONSIN	14.7
7	MICHIGAN	13.4
8	WEST VIRGINIA	13.2
9	NEW MEXICO	13.1
10	COLORADO	12.4
11	TEXAS	12.0
12	MISSISSIPPI	11.6
13	SOUTH CAROLINA	11.5
14	WYOMING	10.1
15	DISTRICT OF COLUMBIA	10.0
16	NEBRASKA	9.7
17	LOUISIANA	8.8
18	KENTUCKY	8.6
19	PENNSYLVANIA	7.6
20	FLORIDA	7.4
21	IDAHO	6.6
22	MAINE	6.3
23	ARKANSAS	6.1
24	CONNECTICUT	6.0
25	KANSAS	5.8
26	MONTANA	5.8
27	NEW HAMPSHIRE	5.5
28	ALABAMA	5.5
29	OHIO	4.9
30	HAWAII	4.6
31	NORTH CAROLINA	4.4
32	SOUTH DAKOTA	4.4
33	WASHINGTON	4.2
34	MINNESOTA	4.2
35	NEW YORK	4.2
36	CALIFORNIA	3.4
37	UTAH	3.2
38	VIRGINIA	3.2
39	NEW JERSEY	3.1
40	MISSOURI	2.5
41	IOWA	2.2
42	NEVADA	1.9
43	MARYLAND	1.7
44	VIRGIN ISLANDS	1.6
45	RHODE ISLAND	1.5
46	DELAWARE	0.9
47	PUERTO RICO	0.8

RANK	VISUAL CONDITIONS PER 100 SCREENED STATE NAME	1976 VALUE
1	TENNESSEE	25.9
2	NORTH DAKOTA	25.8
3	ALASKA	19.9
4	MINNESOTA	18.8
5	OREGON	15.2
6	GEORGIA	13.3
7	COLORADO	12.8
8	MISSISSIPPI	12.0
9	SOUTH CAROLINA	11.9
10	NEW MEXICO	11.8
11	TEXAS	10.9
12	WISCONSIN	10.4
13	FLORIDA	10.2
14	MICHIGAN	10.0
15	KENTUCKY	9.6
16	OKLAHOMA	9.5
17	PENNSYLVANIA	9.4
18	WEST VIRGINIA	9.2
19	LOUISIANA	8.8
20	MARYLAND	7.7
21	DISTRICT OF COLUMBIA	7.7
22	MISSOURI	7.3
23	SOUTH DAKOTA	6.7
24	NEBRASKA	6.6
25	ARKANSAS	6.0
26	NEW HAMPSHIRE	6.0
27	KANSAS	5.9
28	WYOMING	5.9
29	MONTANA	5.4
30	VIRGINIA	4.6
31	PUERTO RICO	4.4
32	IDAHO	4.3
33	HAWAII	3.6
34	NEW JERSEY	3.6
35	ALABAMA	3.4
36	CALIFORNIA	3.2
37	CONNECTICUT	3.1
38	WASHINGTON	2.8
39	UTAH	2.7
40	NORTH CAROLINA	2.5
41	MAINE	2.5
42	IOWA	2.1
43	NEW YORK	1.6
44	DELAWARE	0.7
45	RHODE ISLAND	0.7
46	NEVADA	0.7
47	VIRGIN ISLANDS	0.6

STATE EPSDT PERFORMANCE CRITERIA, STATES LISTED IN RANK ORDER.

RANK	AUDITORY CONDITIONS PER 100 SCREENED STATE NAME	1975 VALUE
1	ALASKA	11.9
2	WYOMING	10.1
3	WEST VIRGINIA	9.4
4	OREGON	6.3
5	NEW MEXICO	5.3
6	HAWAII	5.1
7	DISTRICT OF COLUMBIA	5.1
8	WASHINGTON	4.7
9	KENTUCKY	4.5
10	WISCONSIN	4.2
11	MICHIGAN	3.8
12	TEXAS	3.7
13	CONNECTICUT	3.7
14	IDAHO	3.7
15	ALABAMA	3.3
16	NEBRASKA	3.1
17	KANSAS	3.1
18	PENNSYLVANIA	3.1
19	NEW HAMPSHIRE	3.1
20	MAINE	3.0
21	FLORIDA	2.6
22	NORTH DAKOTA	2.5
23	LOUISIANA	2.5
24	NORTH CAROLINA	2.4
25	MINNESOTA	2.4
26	TENNESSEE	2.2
27	SOUTH CAROLINA	2.0
28	MISSISSIPPI	1.9
29	OHIO	1.8
30	SOUTH DAKOTA	1.7
31	MONTANA	1.6
32	CALIFORNIA	1.6
33	COLORADO	1.6
34	NEW JERSEY	1.5
35	VIRGINIA	1.4
36	OKLAHOMA	1.3
37	UTAH	1.3
38	ARKANSAS	1.2
39	MARYLAND	1.1
40	VIRGIN ISLANDS	1.0
41	MISSOURI	1.0
42	NEW YORK	0.9
43	IOWA	0.8
44	RHODE ISLAND	0.5
45	PUERTO RICO	0.4
46	NEVADA	0.4
47	DELAWARE	0.1

RANK	AUDITORY CONDITIONS PER 100 SCREENED STATE NAME	1976 VALUE
1	NORTH DAKOTA	27.5
2	ALASKA	11.6
3	MINNESOTA	7.0
4	OREGON	6.2
5	KENTUCKY	5.9
6	MISSOURI	4.7
7	MARYLAND	4.7
8	HAWAII	4.7
9	WEST VIRGINIA	4.0
10	KANSAS	3.5
11	NEW HAMPSHIRE	3.4
12	MICHIGAN	3.3
13	WASHINGTON	3.2
14	PENNSYLVANIA	3.1
15	NEW MEXICO	3.1
16	GEORGIA	3.1
17	SOUTH CAROLINA	3.1
18	DISTRICT OF COLUMBIA	3.0
19	WISCONSIN	3.0
20	LOUISIANA	2.9
21	FLORIDA	2.9
22	SOUTH DAKOTA	2.7
23	TENNESSEE	2.6
24	OKLAHOMA	2.4
25	TEXAS	2.4
26	MONTANA	2.3
27	NEBRASKA	2.2
28	CALIFORNIA	2.1
29	ALABAMA	1.8
30	IDAHO	1.8
31	CONNECTICUT	1.7
32	PUERTO RICO	1.7
33	NEW JERSEY	1.7
34	MISSISSIPPI	1.6
35	VIRGINIA	1.5
36	COLORADO	1.5
37	ARKANSAS	1.1
38	WYOMING	1.1
39	NORTH CAROLINA	0.9
40	MAINE	0.9
41	VIRGIN ISLANDS	0.9
42	UTAH	0.7
43	IOWA	0.6
44	NEW YORK	0.5
45	NEVADA	0.4
46	RHODE ISLAND	0.2
47	DELAWARE	0.1

STATE EPSDT PERFORMANCE CRITERIA, STATES LISTED IN RANK ORDER.

RANK	DENTAL CONDITIONS PER 100 SCREENED STATE NAME	1975 VALUE
1	ALABAMA	78.4
2	MONTANA	72.4
3	MISSISSIPPI	61.0
4	NEW HAMPSHIRE	56.5
5	TENNESSEE	51.8
6	SOUTH CAROLINA	49.0
7	TEXAS	46.3
8	NORTH DAKOTA	41.0
9	FLORIDA	39.1
10	ALASKA	36.9
11	WEST VIRGINIA	34.1
12	NEW MEXICO	31.8
13	OREGON	31.0
14	MICHIGAN	30.7
15	KENTUCKY	29.7
16	OKLAHOMA	28.6
17	COLORADO	26.4
18	ARKANSAS	25.5
19	IDAHO	23.9
20	MAINE	21.9
21	LOUISIANA	21.5
22	PENNSYLVANIA	17.6
23	KANSAS	16.8
24	MINNESOTA	16.0
25	HAWAII	14.2
26	NORTH CAROLINA	13.8
27	VIRGIN ISLANDS	13.3
28	DISTRICT OF COLUMBIA	12.7
29	CALIFORNIA	12.4
30	WYOMING	12.3
31	NEVADA	10.5
32	OHIO	9.1
33	VIRGINIA	8.6
34	NEBRASKA	8.0
35	DELAWARE	6.9
36	NEW YORK	6.8
37	IOWA	6.5
38	SOUTH DAKOTA	6.5
39	WASHINGTON	6.5
40	NEW JERSEY	6.1
41	PUERTO RICO	5.8
42	UTAH	5.0
43	MARYLAND	4.5
44	CONNECTICUT	3.6
45	WISCONSIN	3.5
46	MISSOURI	3.1
47	RHODE ISLAND	0.8

RANK	DENTAL CONDITIONS PER 100 SCREENED STATE NAME	1976 VALUE
1	MISSISSIPPI	70.1
2	TENNESSEE	66.0
3	NORTH DAKOTA	62.4
4	GEORGIA	54.7
5	SOUTH CAROLINA	52.1
6	MONTANA	49.7
7	NEW HAMPSHIRE	48.7
8	FLORIDA	48.1
9	ALABAMA	47.2
10	ILLINOIS	39.4
11	ALASKA	33.3
12	WISCONSIN	31.4
13	KENTUCKY	31.4
14	WEST VIRGINIA	29.4
15	COLORADO	27.4
16	OREGON	25.7
17	NEW MEXICO	25.6
18	ARKANSAS	25.5
19	IDAHO	24.8
20	MICHIGAN	23.9
21	LOUISIANA	23.7
22	KANSAS	17.4
23	PENNSYLVANIA	16.4
24	MARYLAND	16.3
25	PUERTO RICO	16.3
26	MAINE	16.1
27	OKLAHOMA	15.3
28	DISTRICT OF COLUMBIA	15.2
29	HAWAII	13.5
30	CALIFORNIA	12.3
31	SOUTH DAKOTA	11.0
32	VIRGINIA	10.5
33	MISSOURI	10.4
34	NORTH CAROLINA	8.2
35	VIRGIN ISLANDS	8.2
36	WYOMING	8.0
37	NEVADA	7.9
38	NEBRASKA	7.4
39	DELAWARE	7.1
40	IOWA	6.5
41	MINNESOTA	5.7
42	NEW JERSEY	5.0
43	WASHINGTON	4.6
44	TEXAS	4.2
45	NEW YORK	3.5
46	UTAH	3.2
47	CONNECTICUT	2.9
48	RHODE ISLAND	0.5

STATE EPSDT PERFORMANCE CRITERIA, STATES LISTED IN RANK ORDER.

RANK	LEAD CONDITIONS PER 100 SCREENED STATE NAME	1975 VALUE
1	NEW MEXICO	5.3
2	DISTRICT OF COLUMBIA	4.2
3	MAINE	3.5
4	OHIO	3.1
5	MICHIGAN	3.0
6	CONNECTICUT	2.9
7	NORTH CAROLINA	1.7
8	TEXAS	1.6
9	WISCONSIN	1.6
10	NEW HAMPSHIRE	1.2
11	NEW YORK	0.9
12	IDAHO	0.5
13	NEW JERSEY	0.5
14	PENNSYLVANIA	0.4
15	KENTUCKY	0.4
16	TENNESSEE	0.4
17	OKLAHOMA	0.2
18	WEST VIRGINIA	0.2
19	GEORGIA	0.1
20	LOUISIANA	0.1
21	VIRGINIA	0.1
22	OREGON	0.1
23	CALIFORNIA	0.1
24	MINNESOTA	0.1
25	MISSOURI	0.1
26	MARYLAND	0.0
27	WASHINGTON	0.0
28	RHODE ISLAND	0.0
29	COLORADO	0.0
30	ALABAMA	0.0
31	KANSAS	0.0
32	DELAWARE	0.0
33	IOWA	0.0
34	SOUTH CAROLINA	0.0
35	PUERTO RICO	0.0
36	ARKANSAS	0.0
37	MISSISSIPPI	0.0

RANK	LEAD CONDITIONS PER 100 SCREENED STATE NAME	1976 VALUE
1	MINNESOTA	4.8
2	DISTRICT OF COLUMBIA	4.1
3	NEW HAMPSHIRE	2.4
4	MICHIGAN	2.3
5	ALASKA	1.9
6	WISCONSIN	1.9
7	CONNECTICUT	1.6
8	HAWAII	1.1
9	PENNSYLVANIA	0.9
10	MAINE	0.7
11	VIRGIN ISLANDS	0.7
12	NEW YORK	0.6
13	TEXAS	0.6
14	MARYLAND	0.5
15	NEW JERSEY	0.5
16	KENTUCKY	0.3
17	OKLAHOMA	0.3
18	MISSOURI	0.2
19	VIRGINIA	0.1
20	NORTH CAROLINA	0.1
21	GEORGIA	0.1
22	IDAHO	0.1
23	LOUISIANA	0.1
24	ARKANSAS	0.0
25	OREGON	0.0
26	SOUTH DAKOTA	0.0
27	SOUTH CAROLINA	0.0
28	COLORADO	0.0
29	DELAWARE	0.0
30	IOWA	0.0
31	WASHINGTON	0.0
32	TENNESSEE	0.0
33	ALABAMA	0.0
34	KANSAS	0.0

STATE EPSDT PERFORMANCE CRITERIA, STATES LISTED IN RANK ORDER.

RANK	OTHER CONDITIONS % OF CONDITIONS STATE NAME	1975 VALUE
1	PUERTO RICO	91.2
2	WISCONSIN	82.1
3	MARYLAND	72.7
4	WASHINGTON	68.7
5	WYOMING	66.8
6	CONNECTICUT	66.6
7	VIRGIN ISLANDS	64.7
8	NEW YORK	63.9
9	MISSOURI	61.1
10	PENNSYLVANIA	60.6
11	OREGON	60.5
12	RHODE ISLAND	60.4
13	NORTH CAROLINA	58.7
14	UTAH	58.5
15	IOWA	57.8
16	CALIFORNIA	55.9
17	NEVADA	53.5
18	HAWAII	53.4
19	DISTRICT OF COLUMBIA	52.8
20	SOUTH DAKOTA	51.7
21	MINNESOTA	51.2
22	NEW JERSEY	51.0
23	MAINE	49.0
24	FLORIDA	48.9
25	VIRGINIA	48.9
26	NEBRASKA	48.9
27	KENTUCKY	48.8
28	MISSISSIPPI	47.8
29	ARKANSAS	46.6
30	WEST VIRGINIA	45.3
31	KANSAS	45.3
32	OHIO	42.7
33	SOUTH CAROLINA	41.6
34	MICHIGAN	41.1
35	TEXAS	40.9
36	COLORADO	40.0
37	LOUISIANA	38.9
38	NEW MEXICO	32.2
39	NORTH DAKOTA	27.4
40	ALABAMA	26.5
41	DELAWARE	23.6
42	TENNESSEE	23.4
43	OKLAHOMA	21.7
44	IDAHO	19.0
45	NEW HAMPSHIRE	16.7
46	MONTANA	16.4
47	ALASKA	13.2

RANK	OTHER CONDITIONS % OF CONDITIONS STATE NAME	1976 VALUE
1	RHODE ISLAND	87.2
2	CONNECTICUT	83.6
3	VIRGIN ISLANDS	83.3
4	WASHINGTON	76.3
5	NEW JERSEY	75.3
6	NEW YORK	71.7
7	PUERTO RICO	70.7
8	NEVADA	69.8
9	CALIFORNIA	69.2
10	TEXAS	68.1
11	OREGON	65.3
12	PENNSYLVANIA	65.2
13	WYOMING	64.7
14	IOWA	61.0
15	MARYLAND	60.0
16	MISSOURI	58.0
17	WISCONSIN	56.8
18	WEST VIRGINIA	56.2
19	DISTRICT OF COLUMBIA	55.0
20	NEBRASKA	54.3
21	UTAH	53.0
22	MINNESOTA	52.2
23	MAINE	51.1
24	OKLAHOMA	49.5
25	LOUISIANA	48.9
26	ARKANSAS	48.5
27	KENTUCKY	48.0
28	HAWAII	47.5
29	SOUTH DAKOTA	45.0
30	KANSAS	44.0
31	MISSISSIPPI	43.8
32	MICHIGAN	43.5
33	FLORIDA	43.1
34	NORTH DAKOTA	41.8
35	COLORADO	41.5
36	SOUTH CAROLINA	38.8
37	NEW MEXICO	37.9
38	NORTH CAROLINA	35.2
39	GEORGIA	29.9
40	NEW HAMPSHIRE	25.3
41	ALABAMA	25.3
42	TENNESSEE	21.8
43	IDAHO	14.0
44	MONTANA	12.7
45	ALASKA	9.2
46	DELAWARE	8.8
47	VIRGINIA	6.1
48	ILLINOIS	4.5

STATE EPSDT PERFORMANCE CRITERIA, STATES LISTED IN RANK ORDER.

RANK	TOTAL CONDITIONS PER 100 SCREENED STATE NAME	1975 VALUE
1	MISSISSIPPI	142.6
2	OREGON	136.2
3	WISCONSIN	133.4
4	ALABAMA	118.6
5	TEXAS	107.7
6	SOUTH CAROLINA	107.1
7	WEST VIRGINIA	103.9
8	NORTH DAKOTA	102.7
9	WYOMING	98.2
10	FLORIDA	96.1
11	TENNESSEE	95.7
12	MONTANA	95.5
13	MICHIGAN	86.6
14	KENTUCKY	84.2
15	NEW MEXICO	81.8
16	NEW HAMPSHIRE	79.6
17	PUERTO RICO	79.3
18	ALASKA	74.4
19	PENNSYLVANIA	72.9
20	OKLAHOMA	70.7
21	MAINE	68.0
22	DISTRICT OF COLUMBIA	67.7
23	COLORADO	67.3
24	ARKANSAS	61.4
25	NORTH CAROLINA	54.1
26	LOUISIANA	53.9
27	HAWAII	51.3
28	WASHINGTON	49.1
29	CONNECTICUT	48.3
30	KANSAS	47.2
31	MINNESOTA	46.3
32	VIRGIN ISLANDS	44.9
33	IDAHO	42.9
34	NEBRASKA	40.7
35	CALIFORNIA	39.7
36	NEW YORK	35.3
37	OHIO	33.0
38	NEVADA	27.6
39	MARYLAND	26.7
40	SOUTH DAKOTA	26.0
41	VIRGINIA	25.9
42	UTAH	22.9
43	IOWA	22.8
44	NEW JERSEY	22.6
45	MISSOURI	17.2
46	DELAWARE	10.3
47	RHODE ISLAND	7.0
48	GEORGIA	0.1

RANK	TOTAL CONDITIONS PER 100 SCREENED STATE NAME	1976 VALUE
1	NORTH DAKOTA	198.7
2	MISSISSIPPI	149.0
3	OREGON	135.7
4	TENNESSEE	120.8
5	SOUTH CAROLINA	109.5
6	WISCONSIN	108.1
7	FLORIDA	107.4
8	GEORGIA	101.4
9	WEST VIRGINIA	97.3
10	KENTUCKY	90.7
11	PENNSYLVANIA	85.7
12	NEW HAMPSHIRE	81.0
13	PUERTO RICO	76.5
14	MINNESOTA	75.8
15	ALASKA	73.4
16	MARYLAND	73.0
17	COLORADO	71.5
18	ALABAMA	70.2
19	MICHIGAN	69.9
20	LOUISIANA	69.4
21	DISTRICT OF COLUMBIA	66.5
22	MONTANA	65.7
23	NEW MEXICO	65.2
24	ARKANSAS	63.5
25	VIRGIN ISLANDS	61.9
26	CALIFORNIA	57.4
27	CONNECTICUT	56.9
28	TEXAS	55.5
29	OKLAHOMA	55.5
30	MISSOURI	53.9
31	KANSAS	47.8
32	WASHINGTON	44.8
33	HAWAII	43.6
34	NEW JERSEY	43.5
35	WYOMING	42.4
36	MAINE	41.3
37	ILLINOIS	41.3
38	SOUTH DAKOTA	37.0
39	IDAHO	36.1
40	NEBRASKA	35.6
41	NEVADA	29.6
42	IOWA	23.4
43	NEW YORK	21.7
44	NORTH CAROLINA	18.3
45	VIRGINIA	17.8
46	UTAH	14.1
47	RHODE ISLAND	10.9
48	DELAWARE	6.7

TABLE 3

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
17 ALABAMA	• FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 35.0 %						
NUMBER REPORTED	130805	30520	1666	1003	23922	6	26597	9598	36195	105715
RELATIVE RANKINGS	22	18	17	11	5	27	6	14	11	11
PER 100 ELIGIBLE		23.3	1.3	0.8	18.3	0.0	20.3	7.3	27.7	80.8
RELATIVE RANKINGS		22	23	15	3	29	6	17	9	11
PER 100 SCREENED			5.5	3.3	78.4	0.0	87.1	31.4	118.6	
RELATIVE RANKINGS			28	15	1	30	1	18	4	
% OF CONDITIONS			4.6	2.8	66.1	0.0	73.5	26.5	100.0	
RELATIVE RANKINGS			45	33	4	33	9	40		
17 ALABAMA	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 43.0 %						
NUMBER REPORTED	138126	39574	1331	730	18696	3	20760	7019	27779	145289
RELATIVE RANKINGS	22	15	23	17	8	31	7	23	14	12
PER 100 ELIGIBLE		28.7	1.0	0.5	13.5	0.0	15.0	5.1	20.1	105.2
RELATIVE RANKINGS		19	26	26	7	33	10	25	12	16
PER 100 SCREENED			3.4	1.8	47.2	0.0	52.5	17.7	70.2	
RELATIVE RANKINGS			35	29	9	33	10	36	18	
% OF CONDITIONS			4.8	2.6	67.5	0.0	74.7	25.3	100.0	
RELATIVE RANKINGS			45	34	5	33	8	41		
49 ALASKA	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 50.6 %						
NUMBER REPORTED	12200	4113	646	490	1519	0	2655	404	3059	8204
RELATIVE RANKINGS	49	43	30	22	29	0	30	42	36	44
PER 100 ELIGIBLE		33.7	5.3	4.0	12.5	0.0	21.8	3.3	25.1	67.2
RELATIVE RANKINGS		11	6	1	8	0	5	30	11	16
PER 100 SCREENED			15.7	11.9	36.9	0.0	64.6	9.8	74.4	
RELATIVE RANKINGS			5	1	10	0	7	44	18	
% OF CONDITIONS			21.1	16.0	49.7	0.0	86.8	13.2	100.0	
RELATIVE RANKINGS			4	1	7	0	2	47		
49 ALASKA	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 61.4 %						
NUMBER REPORTED	11092	4537	901	525	1511	87	3024	305	3329	12741
RELATIVE RANKINGS	49	43	29	26	32	12	31	46	36	42
PER 100 ELIGIBLE		40.9	8.1	4.7	13.6	0.8	27.3	2.7	30.0	114.9
RELATIVE RANKINGS		7	2	1	6	1	5	35	8	9
PER 100 SCREENED			19.9	11.6	33.3	1.9	66.7	6.7	73.4	
RELATIVE RANKINGS			3	2	11	5	6	43	15	
% OF CONDITIONS			27.1	15.8	45.4	2.6	90.8	9.2	100.0	
RELATIVE RANKINGS			1	1	12	7	4	45		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
31 **ARKANSAS** • FISCAL YEAR, 1975 — EFFECTIVENESS COMPARED TO AAP STANDARD = 44.2 %										
NUMBER REPORTED	79636	24910	1492	287	6262	1	8042	7004	15046	54659
RELATIVE RANKINGS	31	21	21	29	15	35	16	18	18	21
PER 100 ELIGIBLE		30.8	1.9	0.4	7.9	0.0	10.1	8.8	18.9	68.6
RELATIVE RANKINGS		13	18	31	17	34	18	11	17	15
PER 100 SCREENED			6.1	1.2	25.5	0.0	32.8	28.6	61.4	
RELATIVE RANKINGS			23	38	18	36	21	20	24	
% OF CONDITIONS			9.9	1.9	41.6	0.0	53.4	46.6	100.0	
RELATIVE RANKINGS			30	40	11	36	20	29		
31 ARKANSAS • FISCAL YEAR, 1976 — EFFECTIVENESS COMPARED TO AAP STANDARD = 41.7 %										
NUMBER REPORTED	88992	24712	1482	277	6313	12	8084	7620	15704	79371
RELATIVE RANKINGS	29	26	21	32	15	26	17	22	23	22
PER 100 ELIGIBLE		27.8	1.7	0.3	7.1	0.0	9.1	8.6	17.6	89.2
RELATIVE RANKINGS		22	21	31	13	25	14	17	17	21
PER 100 SCREENED			6.0	1.1	25.5	0.0	32.7	30.8	63.5	
RELATIVE RANKINGS			25	37	15	24	21	22	24	
% OF CONDITIONS			9.4	1.8	40.2	0.1	51.5	48.5	100.0	
RELATIVE RANKINGS			30	43	15	25	23	26		
46 **CALIFORNIA** FISCAL YEAR, 1975 — EFFECTIVENESS COMPARED TO AAP STANDARD = 2.9 %										
NUMBER REPORTED	1172312	19326	663	311	2401	12	3387	4292	7679	32156
RELATIVE RANKINGS	1	28	29	28	24	24	24	24	26	29
PER 100 ELIGIBLE		1.6	0.1	0.0	0.2	0.0	0.3	0.4	0.7	2.7
RELATIVE RANKINGS		51	47	46	46	35	46	46	46	51
PER 100 SCREENED			3.4	1.6	12.4	0.1	17.5	22.2	39.7	
RELATIVE RANKINGS			36	32	29	23	32	28	35	
% OF CONDITIONS			8.6	4.1	31.3	0.2	44.1	55.9	100.0	
RELATIVE RANKINGS			35	27	26	26	33	16		
46 CALIFORNIA FISCAL YEAR, 1976 — EFFECTIVENESS COMPARED TO AAP STANDARD = 3.7 %										
NUMBER REPORTED	1235444	30290	976	643	3725	0	5344	12032	17376	62446
RELATIVE RANKINGS	1	21	27	18	23	0	26	17	22	27
PER 100 ELIGIBLE		2.5	0.1	0.1	0.3	0.0	0.4	1.0	1.4	5.1
RELATIVE RANKINGS		50	46	44	47	0	47	44	47	51
PER 100 SCREENED			3.2	2.1	12.3	0.0	17.6	39.7	57.4	
RELATIVE RANKINGS			36	28	30	0	34	14	26	
% OF CONDITIONS			5.6	3.7	21.4	0.0	30.8	69.2	100.0	
RELATIVE RANKINGS			43	26	34	0	40	9		

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EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
40 COLORADO	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 66.2 %						
NUMBER REPORTED	80000	35330	4384	558	9313	7	14262	9504	23766	65845
RELATIVE RANKINGS	30	12	10	21	11	26	13	15	13	16
PER 100 ELIGIBLE		44.2	5.5	0.7	11.6	0.0	17.8	11.9	29.7	82.3
RELATIVE RANKINGS		2	5	17	10	22	10	8	6	10
PER 100 SCREENED			12.4	1.6	26.4	0.0	40.4	26.9	67.3	
RELATIVE RANKINGS			10	33	17	29	17	23	23	
% OF CONDITIONS			18.4	2.3	39.2	0.0	60.0	40.0	100.0	
RELATIVE RANKINGS			7	37	16	32	13	36		
40 COLORADO	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 88.2 %						
NUMBER REPORTED	70999	41730	5359	625	11448	13	17445	12380	29825	107575
RELATIVE RANKINGS	33	14	8	20	10	23	11	16	13	18
PER 100 ELIGIBLE		58.8	7.6	0.9	16.1	0.0	24.6	17.4	42.0	151.6
RELATIVE RANKINGS		1	3	14	5	23	8	9	6	4
PER 100 SCREENED			12.8	1.5	27.4	0.0	41.8	29.7	71.5	
RELATIVE RANKINGS			7	36	15	28	15	25	17	
% OF CONDITIONS			18.0	2.1	38.4	0.0	58.5	41.5	100.0	
RELATIVE RANKINGS			10	41	18	28	14	35		
1 CONNECTICUT	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 33.7 %						
NUMBER REPORTED	92430	20772	1240	765	742	601	3348	6677	10025	42402
RELATIVE RANKINGS	27	26	22	14	37	7	25	19	23	23
PER 100 ELIGIBLE		22.5	1.3	0.8	0.8	0.7	3.6	7.2	10.8	45.9
RELATIVE RANKINGS		23	22	13	36	3	27	18	27	25
PER 100 SCREENED			6.0	3.7	3.6	2.9	16.1	32.1	48.3	
RELATIVE RANKINGS			24	13	44	6	33	16	29	
% OF CONDITIONS			12.4	7.6	7.4	6.0	33.4	66.6	100.0	
RELATIVE RANKINGS			20	8	45	5	43	6		
1 CONNECTICUT	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 46.9 %						
NUMBER REPORTED	99798	31203	956	536	901	514	2907	14859	17766	73605
RELATIVE RANKINGS	28	19	28	23	37	5	32	12	19	23
PER 100 ELIGIBLE		31.3	1.0	0.5	0.9	0.5	2.9	14.9	17.8	73.8
RELATIVE RANKINGS		16	27	23	40	2	36	7	15	24
PER 100 SCREENED			3.1	1.7	2.9	1.6	9.3	47.6	56.9	
RELATIVE RANKINGS			37	31	47	7	42	9	27	
% OF CONDITIONS			5.4	3.0	5.1	2.9	16.4	83.6	100.0	
RELATIVE RANKINGS			44	30	47	5	47	2		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
11 **DELAWARE** *	FISCAL YEAR, 1975		EFFECTIVENESS COMPARED TO AAP STANDARD = 32.0 %							
NUMBER REPORTED	24461	5220	46	4	360	1	411	127	538	15080
RELATIVE RANKINGS	45	40	44	47	42	38	42	46	45	39
PER 100 ELIGIBLE		21.4	0.2	0.0	1.5	0.0	1.7	0.5	2.2	61.7
RELATIVE RANKINGS		26	41	47	31	31	35	44	43	18
PER 100 SCREENED			0.9	0.1	6.9	0.0	7.9	2.4	10.3	
RELATIVE RANKINGS			46	47	35	32	43	47	46	
% OF CONDITIONS			8.6	0.7	66.9	0.2	76.4	23.6	100.0	
RELATIVE RANKINGS			37	46	3	22	8	41		
11 DELAWARE	FISCAL YEAR, 1976		EFFECTIVENESS COMPARED TO AAP STANDARD = 53.8 %							
NUMBER REPORTED	23467	8417	63	12	594	2	671	65	736	23497
RELATIVE RANKINGS	42	37	45	46	40	32	42	48	46	38
PER 100 ELIGIBLE		35.9	0.3	0.1	2.5	0.0	2.9	0.3	3.1	100.1
RELATIVE RANKINGS		13	42	45	29	28	37	46	44	18
PER 100 SCREENED			0.7	0.1	7.1	0.0	8.0	0.8	8.7	
RELATIVE RANKINGS			44	47	39	29	45	48	48	
% OF CONDITIONS			8.6	1.6	80.7	0.3	91.2	8.8	100.0	
RELATIVE RANKINGS			32	44	2	21	3	46		
12 **DISTRICT OF COLUMBIA** *	FISCAL YEAR, 1975		EFFECTIVENESS COMPARED TO AAP STANDARD = 10.8 %							
NUMBER REPORTED	104831	7561	753	388	959	314	2414	2704	5118	11685
RELATIVE RANKINGS	26	37	28	25	34	10	31	30	30	41
PER 100 ELIGIBLE		7.2	0.7	0.4	0.9	0.3	2.3	2.6	4.9	11.1
RELATIVE RANKINGS		46	31	30	34	7	34	34	35	45
PER 100 SCREENED			10.0	5.1	12.7	4.2	31.9	35.8	67.7	
RELATIVE RANKINGS			15	7	28	2	23	12	22	
% OF CONDITIONS			14.7	7.6	18.7	6.1	47.2	52.8	100.0	
RELATIVE RANKINGS			15	9	39	4	30	19		
12 DISTRICT OF COLUMBIA *	FISCAL YEAR, 1976		EFFECTIVENESS COMPARED TO AAP STANDARD = 11.7 %							
NUMBER REPORTED	102488	7992	612	241	1212	326	2391	2927	5318	19677
RELATIVE RANKINGS	27	38	33	34	35	7	34	31	34	40
PER 100 ELIGIBLE		7.8	0.6	0.2	1.2	0.3	2.3	2.9	5.2	19.2
RELATIVE RANKINGS		44	37	34	39	6	41	33	38	45
PER 100 SCREENED			7.7	3.0	15.2	4.1	29.9	36.6	66.5	
RELATIVE RANKINGS			21	18	28	2	23	17	21	
% OF CONDITIONS			11.5	4.5	22.8	6.1	45.0	55.0	100.0	
RELATIVE RANKINGS			21	19	31	2	30	19		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

18 FLORIDA • FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 40.5 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	307369	82921	6148	2153	32386	0	40687	38993	79680	184027
RELATIVE RANKINGS	9	5	7	4	3	0	4	5	3	5
PER 100 ELIGIBLE		27.0	2.0	0.7	10.5	0.0	13.2	12.7	25.9	59.9
RELATIVE RANKINGS		17	16	16	12	0	13	6	10	21
PER 100 SCREENED			7.4	2.6	39.1	0.0	49.1	47.0	96.1	
RELATIVE RANKINGS			20	21	9	0	15	7	10	
% OF CONDITIONS			7.7	2.7	40.6	0.0	51.1	48.9	100.0	
RELATIVE RANKINGS			40	34	12	0	25	24		

18 FLORIDA • FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 75.5 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	204315	102896	10461	2944	49458	0	62863	47604	110467	286923
RELATIVE RANKINGS	15	6	6	4	2	0	2	2	2	4
PER 100 ELIGIBLE		50.4	5.1	1.4	24.2	0.0	30.8	23.3	54.1	140.4
RELATIVE RANKINGS		2	6	4	4	0	4	3	4	6
PER 100 SCREENED			10.2	2.9	48.1	0.0	61.1	46.3	107.4	
RELATIVE RANKINGS			13	21	8	0	7	10	7	
% OF CONDITIONS			9.5	2.7	44.8	0.0	56.9	43.1	100.0	
RELATIVE RANKINGS			29	33	14	0	16	33		

19 GEORGIA • FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 11.2 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	291008	21779	0	0	0	23	23	0	23	56762
RELATIVE RANKINGS	11	22	0	0	0	20	48	0	48	20
PER 100 ELIGIBLE		7.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	19.5
RELATIVE RANKINGS		43	0	0	0	24	48	0	48	30
PER 100 SCREENED			0.0	0.0	0.0	0.1	0.1	0.0	0.1	
RELATIVE RANKINGS			0	0	0	19	48	0	48	
% OF CONDITIONS			0.0	0.0	0.0	100.0	100.0	0.0	100.0	
RELATIVE RANKINGS			0	0	0	1	1	0		

19 GEORGIA • FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 68.5 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	246786	112766	14950	3478	61658	74	80160	34159	114319	169528
RELATIVE RANKINGS	11	5	2	3	1	14	1	6	1	19
PER 100 ELIGIBLE		45.7	6.1	1.4	25.0	0.0	32.5	13.8	46.3	68.7
RELATIVE RANKINGS		4	5	5	3	20	2	9	5	28
PER 100 SCREENED			13.3	3.1	54.7	0.1	71.1	30.3	101.4	
RELATIVE RANKINGS			6	16	4	21	4	24	8	
% OF CONDITIONS			13.1	3.0	53.9	0.1	70.1	29.9	100.0	
RELATIVE RANKINGS			16	29	9	27	10	39		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
47 HAWAII *	FISCAL YEAR, 1975		EFFECTIVENESS COMPARED TO AAP STANDARD = 20.3 %							
NUMBER REPORTED	39586	5356	244	275	763	0	1282	1468	2750	17081
RELATIVE RANKINGS	38	39	37	31	36	0	39	35	39	37
PER 100 ELIGIBLE		13.5	0.6	0.7	1.9	0.0	3.2	3.7	6.9	43.1
RELATIVE RANKINGS		33	33	18	28	0	29	28	31	26
PER 100 SCREENED			4.6	5.1	14.2	0.0	23.9	27.4	51.3	
RELATIVE RANKINGS			30	6	25	0	26	22	27	
% OF CONDITIONS			8.9	10.0	27.7	0.0	46.6	53.4	100.0	
RELATIVE RANKINGS			34	3	29	0	31	18		
47 HAWAII	FISCAL YEAR, 1976		EFFECTIVENESS COMPARED TO AAP STANDARD = 26.1 %							
NUMBER REPORTED	40497	7039	255	328	953	76	1610	1456	3066	24120
RELATIVE RANKINGS	39	40	37	31	36	15	39	35	37	37
PER 100 ELIGIBLE		17.4	0.6	0.8	2.4	0.2	4.0	3.6	7.6	59.6
RELATIVE RANKINGS		34	35	17	32	9	28	31	34	30
PER 100 SCREENED			3.6	4.7	13.5	1.1	22.9	20.7	43.6	
RELATIVE RANKINGS			33	8	29	8	28	32	33	
% OF CONDITIONS			8.3	10.7	31.1	2.4	52.5	47.5	100.0	
RELATIVE RANKINGS			33	3	24	8	21	28		
50 IDAHO	FISCAL YEAR, 1975		EFFECTIVENESS COMPARED TO AAP STANDARD = 55.4 %							
NUMBER REPORTED	18800	6945	460	255	1657	38	2410	567	2977	16211
RELATIVE RANKINGS	46	38	34	33	27	17	32	39	37	38
PER 100 ELIGIBLE		36.9	2.4	1.4	8.8	0.2	12.8	3.0	15.8	86.2
RELATIVE RANKINGS		8	15	6	14	10	15	31	19	8
PER 100 SCREENED			6.6	3.7	23.9	0.5	34.7	8.2	42.9	
RELATIVE RANKINGS			21	14	19	12	19	45	33	
% OF CONDITIONS			15.5	8.6	55.7	1.3	81.0	19.0	100.0	
RELATIVE RANKINGS			12	6	5	13	5	44		
50 IDAHO	FISCAL YEAR, 1976		EFFECTIVENESS COMPARED TO AAP STANDARD = 73.7 %							
NUMBER REPORTED	14440	7091	307	129	1762	4	2202	359	2561	23302
RELATIVE RANKINGS	47	39	36	38	30	28	36	45	38	39
PER 100 ELIGIBLE		49.1	2.1	0.9	12.2	0.0	15.2	2.5	17.7	161.4
RELATIVE RANKINGS		3	15	12	9	21	9	36	16	3
PER 100 SCREENED			4.3	1.8	24.8	0.1	31.1	5.1	36.1	
RELATIVE RANKINGS			32	30	19	22	22	45	39	
% OF CONDITIONS			12.0	5.0	68.8	0.2	86.0	14.0	100.0	
RELATIVE RANKINGS			20	14	4	22	6	43		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

25 ILLINOIS — FISCAL YEAR, 1975 — EFFECTIVENESS COMPARED TO AAP STANDARD = 11.1 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	579076	42682	0	0	0	0	0	0	0	62682
RELATIVE RANKINGS	6	10	0	0	0	0	0	0	0	17
PER 100 ELIGIBLE		7.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.8
RELATIVE RANKINGS		45	0	0	0	0	0	0	0	46
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		

25 ILLINOIS — FISCAL YEAR, 1976 — EFFECTIVENESS COMPARED TO AAP STANDARD = 12.5 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	613174	51000	0	0	20105	0	20105	949	21054	113682
RELATIVE RANKINGS	6	10	0	0	6	0	9	36	15	16
PER 100 ELIGIBLE		8.3	0.0	0.0	3.3	0.0	3.3	0.2	3.4	18.5
RELATIVE RANKINGS		43	0	0	24	0	34	48	42	46
PER 100 SCREENED			0.0	0.0	39.4	0.0	39.4	1.9	41.3	
RELATIVE RANKINGS			0	0	10	0	10	46	37	
% OF CONDITIONS			0.0	0.0	95.5	0.0	95.5	4.5	100.0	
RELATIVE RANKINGS			0	0	1	0	1	48		

26 INDIANA — FISCAL YEAR, 1975 — EFFECTIVENESS COMPARED TO AAP STANDARD = 0.0 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	138491	0	0	0	0	0	0	0	0	0
RELATIVE RANKINGS	28	0	0	0	0	0	0	0	0	0
PER 100 ELIGIBLE		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
RELATIVE RANKINGS		0	0	0	0	0	0	0	0	0
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		

26 INDIANA — FISCAL YEAR, 1976 — EFFECTIVENESS COMPARED TO AAP STANDARD = 0.0 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	133135	0	0	0	0	0	0	0	0	0
RELATIVE RANKINGS	23	0	0	0	0	0	0	0	0	0
PER 100 ELIGIBLE		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
RELATIVE RANKINGS		0	0	0	0	0	0	0	0	0
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		

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36 IOWA — FISCAL YEAR, 1975 — EFFECTIVENESS COMPARED TO AAP STANDARD = 55.1 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	57932	21264	477	180	1387	4	2048	2809	4857	70087
RELATIVE RANKINGS	34	24	33	36	31	33	35	29	31	15
PER 100 ELIGIBLE		36.7	0.8	0.3	2.4	0.0	3.5	4.8	8.4	121.0
RELATIVE RANKINGS		10	27	33	26	26	28	27	30	2
PER 100 SCREENED			2.2	0.8	6.5	0.0	9.6	13.2	22.8	
RELATIVE RANKINGS			41	43	37	33	41	40	43	
% OF CONDITIONS			9.8	3.7	28.6	0.1	42.2	57.8	100.0	
RELATIVE RANKINGS			31	30	28	29	34	15		

36 IOWA — FISCAL YEAR, 1976 — EFFECTIVENESS COMPARED TO AAP STANDARD = 56.9 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	65712	24948	523	139	1614	4	2280	3562	5842	95035
RELATIVE RANKINGS	35	25	34	36	31	29	35	27	32	20
PER 100 ELIGIBLE		38.0	0.8	0.2	2.5	0.0	3.5	5.4	8.9	144.6
RELATIVE RANKINGS		11	30	37	31	29	32	23	29	5
PER 100 SCREENED			2.1	0.6	6.5	0.0	9.1	14.3	23.4	
RELATIVE RANKINGS			42	43	40	30	43	39	42	
% OF CONDITIONS			9.0	2.4	27.6	0.1	39.0	61.0	100.0	
RELATIVE RANKINGS			31	36	29	26	35	14		

37 KANSAS • FISCAL YEAR, 1975 — EFFECTIVENESS COMPARED TO AAP STANDARD = 47.1 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	66248	20806	1217	644	3505	4	5370	4444	9814	38029
RELATIVE RANKINGS	33	25	23	17	20	32	20	23	24	25
PER 100 ELIGIBLE		31.4	1.8	1.0	5.3	0.0	8.1	6.7	14.8	57.4
RELATIVE RANKINGS		12	19	9	20	28	20	19	21	23
PER 100 SCREENED			5.8	3.1	16.8	0.0	25.8	21.4	47.2	
RELATIVE RANKINGS			25	17	23	31	25	29	30	
% OF CONDITIONS			12.4	6.6	35.7	0.0	54.7	45.3	100.0	
RELATIVE RANKINGS			19	12	19	31	18	31		

37 KANSAS • FISCAL YEAR, 1976 — EFFECTIVENESS COMPARED TO AAP STANDARD = 35.3 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	76868	18090	1066	631	3146	1	4844	3803	8647	56119
RELATIVE RANKINGS	30	29	26	19	25	33	26	26	27	28
PER 100 ELIGIBLE		23.5	1.4	0.8	4.1	0.0	6.3	4.9	11.2	73.0
RELATIVE RANKINGS		27	23	16	21	34	22	27	26	25
PER 100 SCREENED			5.9	3.5	17.4	0.0	26.8	21.0	47.8	
RELATIVE RANKINGS			27	10	22	34	27	31	31	
% OF CONDITIONS			12.3	7.3	36.4	0.0	56.0	44.0	100.0	
RELATIVE RANKINGS			19	7	19	32	17	30		

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	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
20 KENTUCKY •	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 18.9 %						
NUMBER REPORTED	160307	20196	1728	899	5998	81	8706	8297	17003	145596
RELATIVE RANKINGS	17	27	16	13	16	13	15	16	17	6
PER 100 ELIGIBLE		12.6	1.1	0.6	3.7	0.1	5.4	5.2	10.6	90.8
RELATIVE RANKINGS		35	29	21	23	16	25	26	28	6
PER 100 SCREENED			8.6	4.5	29.7	0.4	43.1	41.1	84.2	
RELATIVE RANKINGS			18	9	15	15	16	11	14	
% OF CONDITIONS			10.2	5.3	35.3	0.5	51.2	48.8	100.0	
RELATIVE RANKINGS			29	19	21	17	22	27		
20 KENTUCKY	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 32.2 %						
NUMBER REPORTED	160000	34303	3285	2013	10782	113	16193	14922	31115	179897
RELATIVE RANKINGS	18	18	12	8	11	10	12	11	11	8
PER 100 ELIGIBLE		21.4	2.1	1.3	6.7	0.1	10.1	9.3	19.4	112.4
RELATIVE RANKINGS		31	16	7	14	14	13	14	14	10
PER 100 SCREENED			9.6	5[illegible]	31.4	0.3	47.2	43.5	90.7	
RELATIVE RANKINGS			15	5	13	18	11	12	10	
% OF CONDITIONS			10.6	6.5	34.7	0.4	52.0	48.0	100.0	
RELATIVE RANKINGS			25	10	20	20	22	27		
32 LOUISIANA •	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 60.0 %						
NUMBER REPORTED	189214	75696	6692	1864	16283	66	24905	15888	40793	193924
RELATIVE RANKINGS	15	6	6	6	7	15	8	9	10	5
PER 100 ELIGIBLE		40.0	3.5	1.0	8.6	0.0	13.2	8.4	21.6	102.5
RELATIVE RANKINGS		5	9	8	15	18	14	13	13	4
PER 100 SCREENED			8.8	2.5	21.5	0.1	32.9	21.0	53.9	
RELATIVE RANKINGS			17	23	21	20	20	30	26	
% OF CONDITIONS			16.4	4.6	39.9	0.2	61.1	38.9	100.0	
RELATIVE RANKINGS			9	22	14	25	12	37		
32 LOUISIANA •	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 34.5 %						
NUMBER REPORTED	189729	43610	3845	1267	10327	24	15463	14793	30256	237534
RELATIVE RANKINGS	16	13	10	10	12	22	13	13	12	5
PER 100 ELIGIBLE		23.0	2.0	0.7	5.4	0.0	8.2	7.8	15.9	125.2
RELATIVE RANKINGS		29	17	21	17	26	18	18	18	8
PER 100 SCREENED			8.8	2.9	23.7	0.1	35.5	33.9	69.4	
RELATIVE RANKINGS			19	20	21	23	20	19	20	
% OF CONDITIONS			12.7	4.2	34.1	0.1	51.1	48.9	100.0	
RELATIVE RANKINGS			18	22	22	24	24	25		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
2 MAINE	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 26.6 %						
NUMBER REPORTED RELATIVE RANKINGS	57090 35	9342 35	588 31	283 30	2047 26	326 9	3244 28	3112 28	6356 27	22610 32
PER 100 ELIGIBLE RELATIVE RANKINGS		16.4 29	1.0 26	0.5 25	3.6 25	0.6 5	5.7 24	5.5 23	11.1 25	39.6 28
PER 100 SCREENED RELATIVE RANKINGS			6.3 22	3.0 20	21.9 20	3.5 3	34.7 18	33.3 15	68.0 21	
% OF CONDITIONS RELATIVE RANKINGS			9.3 32	4.5 23	32.2 25	5.1 6	51.0 26	49.0 23	100.0	
2 MAINE	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 31.5 %						
NUMBER REPORTED RELATIVE RANKINGS	65834 34	13810 32	343 35	130 37	2220 27	96 11	2789 33	2919 32	5708 33	36420 33
PER 100 ELIGIBLE RELATIVE RANKINGS		21.0 32	0.5 38	0.2 40	3.4 22	0.1 11	4.2 26	4.4 29	8.7 31	55.3 31
PER 100 SCREENED RELATIVE RANKINGS			2.5 41	0.9 40	16.1 26	0.7 10	20.2 32	21.1 30	41.3 36	
% OF CONDITIONS RELATIVE RANKINGS			6.0 41	2.3 38	38.9 17	1.7 10	48.9 26	51.1 23	100.0	
13 MARYLAND	• FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 7.1 %						
NUMBER REPORTED RELATIVE RANKINGS	230924 13	10890 33	184 39	115 38	489 39	5 31	793 45	2116 32	2909 38	33400 27
PER 100 ELIGIBLE RELATIVE RANKINGS		4.7 48	0.1 45	0.0 43	0.2 45	0.0 33	0.3 45	0.9 43	1.3 44	14.5 44
PER 100 SCREENED RELATIVE RANKINGS			1.7 43	1.1 39	4.5 43	0.0 26	7.3 44	19.4 32	26.7 39	
% OF CONDITIONS RELATIVE RANKINGS			6.3 43	4.0 28	16.8 41	0.2 23	27.3 46	72.7 3	100.0	
13 MARYLAND	• FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 7.4 %						
NUMBER REPORTED RELATIVE RANKINGS	220196 14	10871 34	834 31	509 25	1773 29	59 18	3175 29	4764 24	7939 28	44271 31
PER 100 ELIGIBLE RELATIVE RANKINGS		4.9 49	0.4 40	0.2 35	0.8 41	0.0 22	1.4 43	2.2 39	3.6 41	20.1 44
PER 100 SCREENED RELATIVE RANKINGS			7.7 20	4.7 7	16.3 24	0.5 14	29.2 29	43.8 11	73.0 16	
% OF CONDITIONS RELATIVE RANKINGS			10.5 26	6.4 11	22.3 33	0.7 12	40.0 34	60.0 15	100.0	

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
3 MASSACHUSETTS	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 15.1 %						
NUMBER REPORTED	246447	24851	0	0	0	0	0	0	0	24891
RELATIVE RANKINGS	12	20	0	0	0	0	0	0	0	31
PER 100 ELIGIBLE		10.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.1
RELATIVE RANKINGS		59	0	0	0	0	0	0	0	47
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		
3 MASSACHUSETTS	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 9.6 %						
NUMBER REPORTED	345436	22134	0	0	0	0	0	0	0	47025
RELATIVE RANKINGS	9	27	0	0	0	0	0	0	0	30
PER 100 ELIGIBLE		6.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	13.6
RELATIVE RANKINGS		48	0	0	0	0	0	0	0	49
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		
27 MICHIGAN *	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 35.2 %						
NUMBER REPORTED	530004	124270	16714	4770	38118	3772	63374	44252	107626	324611
RELATIVE RANKINGS	5	2	1	1	2	1	2	3	2	1
PER 100 ELIGIBLE		23.4	3.2	0.9	7.2	0.7	12.0	8.3	20.3	61.2
RELATIVE RANKINGS		21	10	10	19	2	17	15	14	19
PER 100 SCREENED			13.4	3.8	30.7	3.0	51.0	35.6	86.6	
RELATIVE RANKINGS			7	11	14	5	14	13	13	
% OF CONDITIONS			15.5	4.4	35.4	3.5	58.9	41.1	100.0	
RELATIVE RANKINGS			11	24	20	7	15	34		
27 MICHIGAN *	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 32.6 %						
NUMBER REPORTED	544564	118383	11839	3800	28247	2775	46741	35956	82697	442994
RELATIVE RANKINGS	5	3	4	1	5	1	5	5	5	1
PER 100 ELIGIBLE		21.7	2.2	0.7	5.2	0.5	8.6	6.6	15.2	81.3
RELATIVE RANKINGS		30	14	20	19	3	15	21	19	23
PER 100 SCREENED			10.0	3.3	23.9	2.3	39.5	30.4	69.9	
RELATIVE RANKINGS			14	12	20	4	17	23	19	
% OF CONDITIONS			14.3	4.7	34.2	3.4	56.5	43.5	100.0	
RELATIVE RANKINGS			12	17	21	3	17	32		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
20 MINNESOTA	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 16.1 %						
NUMBER REPORTED	91090	9739	407	231	1564	6	2208	2312	4520	31036
RELATIVE RANKINGS	28	34	36	34	28	28	34	31	32	30
PER 100 ELIGIBLE		10.7	0.4	0.3	1.7	0.0	2.4	2.5	5.0	34.1
RELATIVE RANKINGS		38	38	34	30	27	33	35	34	31
PER 100 SCREENED			4.2	2.4	16.0	0.1	22.6	23.7	46.3	
RELATIVE RANKINGS			34	25	24	24	28	25	31	
% OF CONDITIONS			9.0	5.1	34.6	0.1	48.8	51.2	100.0	
RELATIVE RANKINGS			33	20	22	27	28	21		
20 MINNESOTA	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 11.3 %						
NUMBER REPORTED	112445	8486	1598	590	480	406	3074	3361	6435	39522
RELATIVE RANKINGS	25	36	20	21	41	6	30	29	31	32
PER 100 ELIGIBLE		7.5	1.4	0.5	0.4	0.4	2.7	3.0	5.7	35.1
RELATIVE RANKINGS		45	22	25	45	4	38	32	35	38
PER 100 SCREENED			18.8	7.0	5.7	4.8	36.2	39.6	75.8	
RELATIVE RANKINGS			4	3	41	1	19	13	14	
% OF CONDITIONS			24.8	9.2	7.5	6.3	47.8	52.2	100.0	
RELATIVE RANKINGS			3	4	46	1	27	22		
21 MISSISSIPPI	* FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 36.4 %						
NUMBER REPORTED	151563	36818	4268	691	22447	1	27407	29092	52499	114533
RELATIVE RANKINGS	19	11	11	16	6	34	5	7	7	10
PER 100 ELIGIBLE		24.3	2.8	0.5	14.8	0.0	18.1	16.6	34.6	75.6
RELATIVE RANKINGS		19	12	26	6	36	8	3	5	13
PER 100 SCREENED			11.6	1.9	61.0	0.0	74.4	68.2	142.6	
RELATIVE RANKINGS			12	28	3	37	4	4	1	
% OF CONDITIONS			8.1	1.3	42.8	0.0	52.2	47.8	100.0	
RELATIVE RANKINGS			39	45	13	37	21	28		
21 MISSISSIPPI	* FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 55.4 %						
NUMBER REPORTED	154425	57061	6831	912	40040	0	47783	37255	85038	171614
RELATIVE RANKINGS	19	9	7	13	4	0	4	4	4	9
PER 100 ELIGIBLE		37.0	4.4	0.6	25.9	0.0	30.9	24.1	55.1	111.1
RELATIVE RANKINGS		12	7	22	2	0	3	2	3	12
PER 100 SCREENED			12.0	1.6	70.1	0.0	83.7	65.3	149.0	
RELATIVE RANKINGS			8	34	1	0	3	3	2	
% OF CONDITIONS			8.0	1.1	47.1	0.0	56.2	43.8	100.0	
RELATIVE RANKINGS			36	47	11	0	18	31		

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EPSDT PERFORMANCE BY STATE, 1975 AND 1976

                        ELIGIBLES SCREENINGS  VISUAL  AUDITORY   DENTAL  LEAD P.  SUBTOTAL    OTHER  TOT.COND  CUM.SCREENS

 38 MISSOURI            FISCAL YEAR, 1975             EFFECTIVENESS COMPARED TO AAP STANDARD =  22.9 %

NUMBER REPORTED           215919     32574     839      326      1026      17      2208      3464      5672     57534
  RELATIVE RANKINGS         14         14      26       27        33      23        33        27        28        19

  PER 100 ELIGIBLE                   15.3      0.4      0.2       0.5     0.0       1.0       1.6       2.6      26.6
  RELATIVE RANKINGS                   31       40       39        41      25        42        41        42        32

  PER 100 SCREENED                             2.5      1.0       3.1     0.1       6.7      10.5      17.2
  RELATIVE RANKINGS                            40       41        46      25        46        43        45

  % OF CONDITIONS                             14.8      5.7      18.1     0.3      38.9      61.1     100.0
  RELATIVE RANKINGS                            14       15        40      21        40         9

 38 MISSOURI            FISCAL YEAR, 1976             EFFECTIVENESS COMPARED TO AAP STANDARD =  24.2 %

NUMBER REPORTED           229943     37071    2693     1760      3871      76      8400     11579     19979     94605
  RELATIVE RANKINGS         12         16      13        8        21      13        16        18        17        21

  PER 100 ELIGIBLE                   16.1      1.2      0.8       1.7     0.0       3.7       5.0       8.7      41.1
  RELATIVE RANKINGS                   36       24       19        35      18        30        26        30        37

  PER 100 SCREENED                             7.3      4.7      10.4     0.2      22.7      31.2      53.9
  RELATIVE RANKINGS                            22        6        33      18        29        21        30

  % OF CONDITIONS                             13.5      8.8      19.4     0.4      42.0      58.0     100.0
  RELATIVE RANKINGS                            15        5        37      19        33        16

 41 MONTANA           * FISCAL YEAR, 1975             EFFECTIVENESS COMPARED TO AAP STANDARD =  35.4 %

NUMBER REPORTED            16244      3835     222       62      2777       0      3061       600      3661      9808
  RELATIVE RANKINGS         47         44      38       40        22       0        29        38        33        42

  PER 100 ELIGIBLE                   23.6      1.4      0.4      17.1     0.0      18.8       3.7      22.5      60.4
  RELATIVE RANKINGS                   20       21       29         5       0         8        29        13        20

  PER 100 SCREENED                             5.8      1.6      72.4     0.0      79.8      15.6      95.5
  RELATIVE RANKINGS                            26       31         2       0         2        33        12

  % OF CONDITIONS                              6.1      1.7      75.9     0.0      83.6      16.4     100.0
  RELATIVE RANKINGS                            44       43         1       0         3        46

 41 MONTANA           * FISCAL YEAR, 1976             EFFECTIVENESS COMPARED TO AAP STANDARD =  17.3 %

NUMBER REPORTED            13726      1587      86       36       788       0       910       132      1042     11395
  RELATIVE RANKINGS         48         50      43       42        39       0        40        47        43        44

  PER 100 ELIGIBLE                   11.6      0.6      0.3       5.7     0.0       6.6       1.0       7.6      83.0
  RELATIVE RANKINGS                   41       36       33        16       0        21        45        33        22

  PER 100 SCREENED                             5.4      2.3      49.7     0.0      57.3       8.3      65.7
  RELATIVE RANKINGS                            29       26         6       0         9        41        22

  % OF CONDITIONS                              8.3      3.5      75.6     0.0      87.3      12.7     100.0
  RELATIVE RANKINGS                            35       28         3       0         5        44
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EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
39 NEBRASKA	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 41.1 %						
NUMBER REPORTED RELATIVE RANKINGS	29941 48	8199 36	796 27	256 32	655 38	0 0	1705 37	1631 34	3336 34	18808 34
PER 100 ELIGIBLE RELATIVE RANKINGS		27.4 15	2.7 14	0.9 12	2.2 27	0.0 0	5.7 23	5.4 24	11.1 24	62.8 17
PER 100 SCREENED RELATIVE RANKINGS			9.7 16	3.1 16	8.0 34	0.0 0	20.8 30	19.9 31	40.7 34	
% OF CONDITIONS RELATIVE RANKINGS			23.8 3	7.7 7	19.6 37	0.0 0	51.1 23	48.9 26	100.0	
39 NEBRASKA	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 57.4 %						
NUMBER REPORTED RELATIVE RANKINGS	28038 48	10724 35	712 32	241 33	793 38	0 0	1746 37	2073 34	3819 35	29532 36
PER 100 ELIGIBLE RELATIVE RANKINGS		38.2 10	2.5 13	0.9 15	2.8 26	0.0 0	6.2 23	7.4 20	13.6 23	105.3 15
PER 100 SCREENED RELATIVE RANKINGS			6.6 24	2.2 27	7.4 3[illegible]	0.0 0	16.3 38	19.3 35	35.6 40	
% OF CONDITIONS RELATIVE RANKINGS			18.6 7	6.3 12	20.8 36	0.0 0	45.7 29	54.3 20	100.0	
48 NEVADA	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 60.3 %						
NUMBER REPORTED RELATIVE RANKINGS	103[illegible] 5[illegible]	4145 42	79 43	18 44	435 41	0 0	532 41	612 37	1144 41	12348 40
PER 100 ELIGIBLE RELATIVE RANKINGS		40.2 4	0.8 30	0.2 37	4.2 21	0.0 0	5.2 26	5.9 22	11.1 26	119.7 3
PER 100 SCREENED RELATIVE RANKINGS			1.9 42	0.4 46	10.5 31	0.0 0	12.8 37	14.8 35	27.6 38	
% OF CONDITIONS RELATIVE RANKINGS			6.9 42	1.6 44	38.0 18	0.0 0	46.5 32	53.5 17	100.0	
48 NEVADA	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 63.1 %						
NUMBER REPORTED RELATIVE RANKINGS	10131 51	4261 44	29 46	17 45	336 43	0 0	382 46	881 37	1263 42	16609 41
PER 100 ELIGIBLE RELATIVE RANKINGS		42.1 8	0.3 41	0.2 41	3.3 23	0.0 0	3.8 29	8.7 16	12.5 24	163.9 2
PER 100 SCREENED RELATIVE RANKINGS			0.7 46	0.4 45	7.9 37	0.0 0	9.0 44	20.7 33	29.6 41	
% OF CONDITIONS RELATIVE RANKINGS			2.3 46	1.3 46	26.6 30	0.0 0	30.2 41	69.8 8	100.0	

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
4 NEW HAMPSHIRE	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 21.5 %						
NUMBER REPORTED	18675	2670	148	82	1512	33	1775	357	2132	3739
RELATIVE RANKINGS	45	46	40	39	30	18	36	43	40	47
PER 100 ELIGIBLE		14.3	0.8	0.4	8.1	0.2	9.5	1.9	11.4	20.0
RELATIVE RANKINGS		32	29	28	16	11	19	39	23	37
PER 100 SCREENED			5.5	3.1	56.5	1.2	66.3	13.3	79.6	
RELATIVE RANKINGS			27	19	6	10	6	39	16	
% OF CONDITIONS			6.9	3.8	70.9	1.5	83.3	16.7	100.0	
RELATIVE RANKINGS			41	29	2	11	4	45		
4 NEW HAMPSHIRE	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 20.3 %						
NUMBER REPORTED	20790	2811	168	95	1369	68	1700	577	2277	6550
RELATIVE RANKINGS	43	47	39	39	34	14	38	39	40	49
PER 100 ELIGIBLE		13.5	0.8	0.5	6.6	0.3	8.2	2.8	11.0	31.5
RELATIVE RANKINGS		38	29	27	19	5	17	34	27	40
PER 100 SCREENED			6.0	3.4	48.7	2.4	60.5	20.5	81.0	
RELATIVE RANKINGS			26	11	7	3	8	34	12	
% OF CONDITIONS			7.4	4.2	60.1	3.0	74.7	25.3	100.0	
RELATIVE RANKINGS			37	23	6	4	9	40		
7 NEW JERSEY	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 5.7 %						
NUMBER REPORTED	376944	14211	441	207	862	64	1574	1635	3209	21211
RELATIVE RANKINGS	8	29	35	35	35	16	38	33	35	33
PER 100 ELIGIBLE		3.8	0.1	0.1	0.2	0.0	0.4	0.4	0.9	5.6
RELATIVE RANKINGS		50	43	42	44	21	44	45	45	50
PER 100 SCREENED			3.1	1.5	6.1	0.5	11.1	11.5	22.6	
RELATIVE RANKINGS			39	34	40	13	40	42	44	
% OF CONDITIONS			13.7	6.5	26.9	2.0	49.0	51.0	100.0	
RELATIVE RANKINGS			17	14	31	10	27	22		
7 NEW JERSEY	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 18.0 %						
NUMBER REPORTED	378392	47385	1711	799	2360	214	5084	15539	20623	68596
RELATIVE RANKINGS	8	12	15	15	26	9	25	10	16	26
PER 100 ELIGIBLE		12.5	0.5	0.2	0.6	0.1	1.3	4.1	5.5	18.1
RELATIVE RANKINGS		40	39	38	43	15	44	30	37	47
PER 100 SCREENED			3.6	1.7	5.0	0.5	10.7	32.8	43.5	
RELATIVE RANKINGS			34	33	42	15	39	20	34	
% OF CONDITIONS			8.3	3.9	11.4	1.0	24.7	75.3	100.0	
RELATIVE RANKINGS			34	25	43	13	44	5		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
33 NEW MEXICO	• FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 45.7 %						
NUMBER REPORTED	45574	13900	1819	734	4423	735	7711	3658	11369	18664
RELATIVE RANKINGS	37	30	15	15	17	6	17	28	27	35
PER 100 ELIGIBLE		30.5	4.0	1.6	9.7	1.6	16.9	8.0	24.9	41.0
RELATIVE RANKINGS		14	8	4	13	1	12	16	12	27
PER 100 SCREENED			13.1	5.3	31.8	5.3	55.5	26.3	81.8	
RELATIVE RANKINGS			9	5	12	1	11	24	15	
% OF CONDITIONS			16.0	6.5	38.9	6.5	67.8	32.2	100.0	
RELATIVE RANKINGS			10	13	17	3	11	30		
33 NEW MEXICO	• FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 46.1 %						
NUMBER REPORTED	44907	13804	1631	430	3529	5	5590	3405	8995	32468
RELATIVE RANKINGS	37	33	19	20	24	0	23	20	25	35
PER 100 ELIGIBLE		30.7	3.6	1.0	7.9	0.0	12.4	7.6	20.0	72.3
RELATIVE RANKINGS		17	9	9	12	0	17	19	13	26
PER 100 SCREENED			11.8	3.1	25.6	0.0	40.5	24.7	65.2	
RELATIVE RANKINGS			10	15	17	0	16	29	23	
% OF CONDITIONS			18.1	4.8	39.2	0.0	62.1	37.9	100.0	
RELATIVE RANKINGS			8	16	16	0	12	37		
8 NEW YORK	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 16.3 %						
NUMBER REPORTED	1160119	126856	5270	1090	8645	1122	16127	28590	44717	211829
RELATIVE RANKINGS	[illegible]	1	8	9	13	3	12	6	8	3
PER 100 ELIGIBLE		10.9	0.5	0.1	0.7	0.1	1.4	2.4	3.8	18.1
RELATIVE RANKINGS		37	36	40	39	13	40	36	37	39
PER 100 SCREENED			4.2	0.9	6.8	0.9	12.7	22.5	35.3	
RELATIVE RANKINGS			35	42	36	11	38	26	36	
% OF CONDITIONS			11.8	2.4	19.3	2.5	36.1	63.9	100.0	
RELATIVE RANKINGS			23	35	38	9	41	8		
8 NEW YORK	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 21.3 %						
NUMBER REPORTED	1169119	165876	2587	828	5762	1043	10220	25851	36071	377703
RELATIVE RANKINGS	2	1	14	16	15	2	15	7	9	2
PER 100 ELIGIBLE		14.2	0.2	0.1	0.5	0.1	0.9	2.2	3.1	32.3
RELATIVE RANKINGS		37	43	43	44	13	45	37	45	39
PER 100 SCREENED			1.6	0.5	3.5	0.6	6.2	15.6	21.7	
RELATIVE RANKINGS			43	44	45	12	47	38	43	
% OF CONDITIONS			7.2	2.3	16.0	2.9	28.3	71.7	100.0	
RELATIVE RANKINGS			30	37	41	6	43	6		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

22 NORTH CAROLINA • FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 39.8 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	165000	43805	1930	1090	6056	739	9775	13921	23696	61970
RELATIVE RANKINGS	16	9	16	10	15	5	14	11	14	10
PER 100 ELIGIBLE		26.5	1.2	0.6	3.7	0.4	5.9	8.4	14.4	37.6
RELATIVE RANKINGS		18	24	20	24	6	22	12	22	30
PER 100 SCREENED			4.4	2.4	13.8	1.7	22.3	31.8	54.1	
RELATIVE RANKINGS			31	24	26	7	29	17	25	
% OF CONDITIONS			8.1	4.6	25.6	3.1	41.3	58.7	100.0	
RELATIVE RANKINGS			38	29	32	8	36	13		

22 NORTH CAROLINA FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 45.7 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	160000	48710	1240	460	4014	63	5777	3140	8917	110688
RELATIVE RANKINGS	17	11	24	27	20	17	21	30	26	17
PER 100 ELIGIBLE		30.4	0.8	0.3	2.5	0.0	3.6	2.0	5.6	69.2
RELATIVE RANKINGS		18	31	32	30	17	31	40	36	27
PER 100 SCREENED			2.5	0.9	8.2	0.1	11.9	6.4	18.3	
RELATIVE RANKINGS			40	39	34	20	38	44	44	
% OF CONDITIONS			13.9	5.2	45.0	0.7	64.8	35.2	100.0	
RELATIVE RANKINGS			13	13	13	17	11	38		

42 NORTH DAKOTA FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 76.4 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	9852	5020	1564	126	2056	0	3744	1414	5158	8404
RELATIVE RANKINGS	51	41	19	37	25	0	23	36	29	43
PER 100 ELIGIBLE		51.0	15.9	1.3	20.9	0.0	38.0	14.4	52.4	85.3
RELATIVE RANKINGS		1	1	7	1	0	1	5	1	9
PER 100 SCREENED			31.2	2.5	41.0	0.0	74.6	28.2	102.7	
RELATIVE RANKINGS			1	22	8	0	3	21	8	
% OF CONDITIONS			30.3	2.4	39.9	0.0	72.6	27.4	100.0	
RELATIVE RANKINGS			2	36	15	0	10	39		

42 NORTH DAKOTA FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 10.3 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	10133	699	180	192	436	0	808	581	1389	9103
RELATIVE RANKINGS	50	51	38	35	42	0	41	38	41	46
PER 100 ELIGIBLE		6.9	1.8	1.9	4.3	0.0	8.0	5.7	13.7	89.8
RELATIVE RANKINGS		47	20	3	20	0	19	22	22	20
PER 100 SCREENED			25.8	27.5	62.4	0.0	115.6	83.1	198.7	
RELATIVE RANKINGS			2	1	3	0	1	2	1	
% OF CONDITIONS			13.0	13.8	31.4	0.0	58.2	41.8	100.0	
RELATIVE RANKINGS			17	[illegible]	23	0	15	34		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
29 OHIO	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 12.8 %						
NUMBER REPORTED	389765	33221	1634	591	3014	1042	6281	4681	10962	37321
RELATIVE RANKINGS	7	13	18	19	21	4	19	22	21	26
PER 100 ELIGIBLE		8.5	0.4	0.2	0.8	0.3	1.6	1.2	2.8	9.6
RELATIVE RANKINGS		40	39	38	37	8	38	42	41	40
PER 100 SCREENED			4.9	1.8	9.1	3.1	18.9	14.1	33.0	
RELATIVE RANKINGS			29	29	32	4	31	36	37	
% OF CONDITIONS			14.9	5.4	27.5	9.5	57.3	42.7	100.0	
RELATIVE RANKINGS			13	18	30	2	17	32		
29 OHIO	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 29.2 %						
NUMBER REPORTED	397370	66703	0	0	0	0	0	0	0	104026
RELATIVE RANKINGS	7	7	0	0	0	0	0	0	0	19
PER 100 ELIGIBLE		16.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	26.2
RELATIVE RANKINGS		35	0	0	0	0	0	0	0	42
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		
34 OKLAHOMA	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 61.5 %						
NUMBER REPORTED	79011	32403	8175	431	9256	70	17932	4984	22916	118264
RELATIVE RANKINGS	32	15	4	26	12	14	10	21	15	9
PER 100 ELIGIBLE		41.0	10.3	0.5	11.7	0.1	22.7	6.3	29.0	149.7
RELATIVE RANKINGS		3	2	23	9	15	4	21	8	1
PER 100 SCREENED			25.2	1.3	28.6	0.2	55.3	15.4	70.7	
RELATIVE RANKINGS			2	36	16	17	12	34	20	
% OF CONDITIONS			35.7	1.9	40.4	0.3	78.3	21.7	100.0	
RELATIVE RANKINGS			1	41	13	20	6	43		
34 OKLAHOMA	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 29.5 %						
NUMBER REPORTED	72779	14308	1360	344	2193	37	3934	3859	7793	132572
RELATIVE RANKINGS	31	31	22	30	28	20	27	25	29	13
PER 100 ELIGIBLE		19.7	1.9	0.5	3.0	0.1	5.4	5.3	10.7	182.2
RELATIVE RANKINGS		33	19	26	25	16	24	24	28	1
PER 100 SCREENED			9.5	2.4	15.3	0.3	27.5	27.0	54.5	
RELATIVE RANKINGS			16	24	27	17	26	27	29	
% OF CONDITIONS			17.5	4.4	28.1	0.5	50.5	49.5	100.0	
RELATIVE RANKINGS			11	20	28	18	25	26		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
51 OREGON FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 35.3 %										
NUMBER REPORTED	82600	30425	4992	1917	9422	20	16351	25087	41438	42415
RELATIVE RANKINGS	29	18	9	5	10	23	11	8	9	22
PER 100 ELIGIBLE		36.8	6.0	2.3	11.4	0.0	19.8	30.4	50.2	51.3
RELATIVE RANKINGS		9	4	2	11	19	7	1	2	24
PER 100 SCREENED			16.4	6.3	31.6	0.1	53.7	82.5	136.2	
RELATIVE RANKINGS			4	4	13	22	13	2	2	
% OF CONDITIONS			12.0	4.6	22.7	0.0	39.5	60.5	100.0	
RELATIVE RANKINGS			22	21	35	36	38	11		
51 OREGON * FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 61.3 %										
NUMBER REPORTED	71009	29039	4406	1808	7462	13	13689	25725	39414	71454
RELATIVE RANKINGS	32	23	9	7	15	24	14	8	8	25
PER 100 ELIGIBLE		40.8	6.2	2.5	10.5	0.0	19.3	36.2	55.5	100.6
RELATIVE RANKINGS		8	4	2	10	24	7	1	1	17
PER 100 SCREENED			15.2	6.2	25.7	0.0	47.1	88.6	135.7	
RELATIVE RANKINGS			5	4	16	25	12	1	3	
% OF CONDITIONS			11.2	4.6	18.9	0.0	34.7	65.3	100.0	
RELATIVE RANKINGS			22	18	39	30	38	11		
14 PENNSYLVANIA FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 32.3 %										
NUMBER REPORTED	424472	91517	6935	2824	16151	392	26302	40425	66727	97361
RELATIVE RANKINGS	6	4	5	3	8	8	7	4	4	13
PER 100 ELIGIBLE		21.6	1.6	0.7	3.8	0.1	6.2	9.5	15.7	22.9
RELATIVE RANKINGS		25	20	19	22	14	21	10	20	35
PER 100 SCREENED			7.6	3.1	17.6	0.4	28.7	44.2	72.9	
RELATIVE RANKINGS			19	18	22	14	24	9	19	
% OF CONDITIONS			[illegible]	4.2	24.2	0.6	39.4	60.6	100.0	
RELATIVE RANKINGS			[illegible]	26	34	16	39	10		
14 PENNSYLVANIA FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 42.9 %										
NUMBER REPORTED	425000	121568	11426	3819	19943	1036	36224	67948	104172	218929
RELATIVE RANKINGS	6	2	5	2	7	3	6	1	3	6
PER 100 ELIGIBLE		28.6	2.7	0.9	4.7	0.2	8.5	16.0	24.5	51.5
RELATIVE RANKINGS		20	12	11	19	7	16	6	10	33
PER 100 SCREENED			9.4	3.1	16.4	0.9	29.8	55.9	85.7	
RELATIVE RANKINGS			17	14	23	9	24	5	11	
% OF CONDITIONS			11.0	3.7	19.1	1.0	34.8	65.2	100.0	
RELATIVE RANKINGS			23	27	38	14	37	12		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
9 PUERTO RICO	• FISCAL YEAR, 1975				EFFECTIVENESS COMPARED TO AAP STANDARD = 11.1 %					
NUMBER REPORTED	999865	74255	573	333	4297	5	5208	53688	58896	89255
RELATIVE RANKINGS	3	7	32	26	18	30	21	1	5	14
PER 100 ELIGIBLE		7.4	0.1	0.0	0.4	0.0	0.5	5.4	5.9	8.9
RELATIVE RANKINGS		44	46	44	43	37	43	25	32	49
PER 100 SCREENED			0.8	0.4	5.8	0.0	7.0	72.3	79.3	
RELATIVE RANKINGS			47	45	41	35	45	3	17	
% OF CONDITIONS			1.0	0.6	7.3	0.0	8.8	91.2	100.0	
RELATIVE RANKINGS			47	47	46	35	48	1		
9 PUERTO RICO	• FISCAL YEAR, 1976				EFFECTIVENESS COMPARED TO AAP STANDARD = 3.6 %					
NUMBER REPORTED	1070540	25735	1144	434	4197	0	5775	13906	19681	114990
RELATIVE RANKINGS	3	24	25	28	19	0	22	14	18	15
PER 100 ELIGIBLE		2.4	0.1	0.0	0.4	0.0	0.5	1.3	1.8	10.7
RELATIVE RANKINGS		51	45	46	46	0	46	42	46	50
PER 100 SCREENED			4.4	1.7	16.3	0.0	22.4	54.0	76.5	
RELATIVE RANKINGS			31	32	25	0	30	7	13	
% OF CONDITIONS			5.8	2.2	21.3	0.0	29.3	70.7	100.0	
RELATIVE RANKINGS			42	39	35	0	42	7		
5 RHODE ISLAND	FISCAL YEAR, 1975				EFFECTIVENESS COMPARED TO AAP STANDARD = 9.6 %					
NUMBER REPORTED	37317	2356	35	12	19	1	67	102	169	6371
RELATIVE RANKINGS	39	47	45	46	47	37	47	47	47	45
PER 100 ELIGIBLE		6.4	0.1	0.0	0.1	0.0	0.2	0.3	0.5	17.1
RELATIVE RANKINGS		47	44	45	47	32	47	47	47	41
PER 100 SCREENED			1.5	0.5	0.8	0.0	2.8	4.3	7.0	
RELATIVE RANKINGS			45	44	47	28	47	46	47	
% OF CONDITIONS			20.7	7.1	11.2	0.6	39.6	60.4	100.0	
RELATIVE RANKINGS			5	10	44	15	37	12		
5 RHODE ISLAND	FISCAL YEAR, 1976				EFFECTIVENESS COMPARED TO AAP STANDARD = 15.9 %					
NUMBER REPORTED	42902	4537	31	10	22	0	63	430	493	10908
RELATIVE RANKINGS	38	42	45	47	48	0	48	42	48	45
PER 100 ELIGIBLE		10.6	0.1	0.0	0.1	0.0	0.1	1.0	1.1	25.4
RELATIVE RANKINGS		42	47	47	48	0	48	43	48	43
PER 100 SCREENED			0.7	0.2	0.5	0.0	1.4	9.5	10.9	
RELATIVE RANKINGS			45	46	48	0	48	40	47	
% OF CONDITIONS			6.3	2.0	4.5	0.0	12.8	87.2	100.0	
RELATIVE RANKINGS			39	42	48	0	48	1		

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23 SOUTH CAROLINA * FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 40.9 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	110483	30138	3461	591	14779	5	18836	13429	32265	100846
RELATIVE RANKINGS	24	19	12	18	9	29	9	12	12	12
PER 100 ELIGIBLE		27.3	3.1	0.5	13.4	0.0	17.0	12.2	29.2	91.3
RELATIVE RANKINGS		16	11	24	7	30	11	7	7	5
PER 100 SCREENED			11.5	2.0	49.0	0.0	62.5	44.6	107.1	
RELATIVE RANKINGS			13	27	6	34	9	8	6	
% OF CONDITIONS			10.7	1.8	45.8	0.0	58.4	41.6	100.0	
RELATIVE RANKINGS			26	42	5	34	16	33		

23 SOUTH CAROLINA * FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 37.5 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	121111	30272	3592	927	15770	12	20301	12851	33152	131118
RELATIVE RANKINGS	24	22	11	12	9	29	8	15	10	14
PER 100 ELIGIBLE		25.0	3.0	0.8	13.0	0.0	16.8	10.6	27.4	108.3
RELATIVE RANKINGS		24	11	18	8	27	8	12	9	13
PER 100 SCREENED			11.9	3.1	52.1	0.0	67.1	42.5	109.5	
RELATIVE RANKINGS			9	17	5	27	5	13	5	
% OF CONDITIONS			10.8	2.8	47.6	0.0	61.2	38.8	100.0	
RELATIVE RANKINGS			24	31	13	29	13	36		

43 SOUTH DAKOTA FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 18.8 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	18200	2285	100	39	148	0	287	307	594	2726
RELATIVE RANKINGS	46	48	42	42	45	0	44	44	44	50
PER 100 ELIGIBLE		12.6	0.5	0.2	0.8	0.0	1.6	1.7	3.3	15.0
RELATIVE RANKINGS		36	34	35	35	0	37	40	40	43
PER 100 SCREENED			4.4	1.7	6.5	0.0	12.6	13.4	26.0	
RELATIVE RANKINGS			32	30	39	0	39	37	40	
% OF CONDITIONS			16.8	6.6	24.9	0.0	48.3	51.7	100.0	
RELATIVE RANKINGS			8	11	33	0	29	20		

43 SOUTH DAKOTA FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 19.5 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	18582	2420	161	65	265	1	492	403	895	5146
RELATIVE RANKINGS	44	48	41	40	45	34	43	43	44	50
PER 100 ELIGIBLE		13.0	0.9	0.3	1.4	0.0	2.6	2.2	4.8	27.7
RELATIVE RANKINGS		39	28	30	37	30	39	38	39	41
PER 100 SCREENED			6.7	2.7	11.0	0.0	20.3	16.7	37.0	
RELATIVE RANKINGS			23	22	31	26	31	37	38	
% OF CONDITIONS			18.0	7.3	29.6	0.1	55.0	45.0	100.0	
RELATIVE RANKINGS			9	8	26	23	27	29		

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24 TENNESSEE • FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 56.1 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	156874	58624	11064	1272	30375	215	42926	13149	56075	119526
RELATIVE RANKINGS	18	8	3	7	4	12	3	13	6	8
PER 100 ELIGIBLE		37.4	7.1	0.8	19.4	0.1	27.4	8.4	35.7	76.2
RELATIVE RANKINGS		7	3	14	2	12	2	14	4	12
PER 100 SCREENED			18.9	2.2	51.8	0.4	73.2	22.4	95.7	
RELATIVE RANKINGS			3	26	5	16	5	27	11	
% OF CONDITIONS			19.7	2.3	54.2	0.4	76.6	23.4	100.0	
RELATIVE RANKINGS			6	38	6	18	7	42		

24 TENNESSEE • FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 68.4 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	140197	63937	16530	1638	42190	6	60364	16856	77220	183463
RELATIVE RANKINGS	21	8	1	9	3	27	3	9	6	7
PER 100 ELIGIBLE		45.6	11.8	1.2	30.1	0.0	43.1	12.0	55.1	130.9
RELATIVE RANKINGS		5	1	8	1	31	1	11	2	7
PER 100 SCREENED			25.9	2.6	66.0	0.0	94.4	26.4	120.8	
RELATIVE RANKINGS			1	23	2	32	2	28	4	
% OF CONDITIONS			21.4	2.1	54.6	0.0	78.2	21.8	100.0	
RELATIVE RANKINGS			4	40	8	34	7	42		

35 TEXAS • FISCAL YEAR, 1975 EFFECTIVENESS COMPARED TO AAP STANDARD = 58.4 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	303548	118248	14228	4357	54772	1919	75276	52058	127334	214276
RELATIVE RANKINGS	10	3	2	2	1	2	1	2	1	2
PER 100 ELIGIBLE		39.0	4.7	1.4	18.0	0.6	24.8	17.1	41.9	70.6
RELATIVE RANKINGS		6	7	5	4	4	3	2	3	14
PER 100 SCREENED			12.0	3.7	46.3	1.6	63.7	44.0	107.7	
RELATIVE RANKINGS			11	12	7	8	8	10	5	
% OF CONDITIONS			11.2	3.4	43.0	1.5	59.1	40.9	100.0	
RELATIVE RANKINGS			24	31	9	12	14	35		

35 TEXAS • FISCAL YEAR, 1976 EFFECTIVENESS COMPARED TO AAP STANDARD = 58.4 %

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
NUMBER REPORTED	291486	113405	11961	2769	4712	699	20081	42887	62968	327681
RELATIVE RANKINGS	10	4	3	5	18	4	10	3	7	3
PER 100 ELIGIBLE		38.9	4.1	0.9	1.6	0.2	6.9	14.7	21.6	112.4
RELATIVE RANKINGS		9	8	10	36	8	20	8	11	11
PER 100 SCREENED			10.5	2.4	4.2	0.6	17.7	37.8	55.5	
RELATIVE RANKINGS			11	25	44	13	33	16	28	
% OF CONDITIONS			19.0	4.3	7.5	1.1	31.9	68.1	100.0	
RELATIVE RANKINGS			6	21	45	12	39	10		

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	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
44 UTAH	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 2[illegible].2 %						
NUMBER REPORTED	22772	3521	113	46	176	0	335	472	807	9552
RELATIVE RANKINGS	42	45	41	41	44	0	43	40	42	46
PER 100 ELIGIBLE		15.5	0.5	0.2	0.8	0.0	1.5	2.1	3.5	24.4
RELATIVE RANKINGS		30	35	36	38	0	38	38	39	34
PER 100 SCREENED			3.2	1.3	5.0	0.0	9.5	13.4	22.9	
RELATIVE RANKINGS			37	37	42	0	42	38	42	
% OF CONDITIONS			14.0	5.7	21.8	0.0	41.5	58.5	100.0	
RELATIVE RANKINGS			16	16	36	0	35	14		
44 UTAH	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 35.3 %						
NUMBER REPORTED	25811	6072	166	42	195	0	403	455	858	11624
RELATIVE RANKINGS	41	41	40	41	46	0	45	40	45	43
PER 100 ELIGIBLE		23.5	0.6	0.2	0.8	0.0	1.6	1.8	3.3	45.0
RELATIVE RANKINGS		28	34	42	42	0	42	41	43	35
PER 100 SCREENED			2.7	0.7	3.2	0.0	6.6	7.5	14.1	
RELATIVE RANKINGS			39	42	46	0	46	42	46	
% OF CONDITIONS			19.3	4.9	22.7	0.0	47.0	53.0	100.0	
RELATIVE RANKINGS			5	15	32	0	28	21		
6 VERMONT	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 11.8 %						
NUMBER REPORTED	14928	1175	0	0	0	0	0	0	0	3669
RELATIVE RANKINGS	48	50	0	0	0	0	0	0	0	48
PER 100 ELIGIBLE		7.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	24.6
RELATIVE RANKINGS		42	0	0	0	0	0	0	0	33
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		
6 VERMONT	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 38.4 %						
NUMBER REPORTED	16004	4056	0	0	0	0	0	0	0	7763
RELATIVE RANKINGS	46	45	0	0	0	0	0	0	0	47
PER 100 ELIGIBLE		25.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	48.5
RELATIVE RANKINGS		23	0	0	0	0	0	0	0	34
PER 100 SCREENED			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0	0	
% OF CONDITIONS			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
RELATIVE RANKINGS			0	0	0	0	0	0		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
10 VIRGIN ISLANDS • FISCAL YEAR, 1975				EFFECTIVENESS COMPARED TO AAP STANDARD = 12.2 %						
NUMBER REPORTED	19730	1663	25	16	213	0	254	465	719	3303
RELATIVE RANKINGS	43	49	46	45	43	0	45	41	43	49
PER 100 ELIGIBLE		8.1	0.1	0.1	1.1	0.0	1.3	2.4	3.6	16.7
RELATIVE RANKINGS		41	42	41	33	0	41	37	38	42
PER 100 SCREENED			1.6	1.0	13.3	0.0	15.8	29.0	44.9	
RELATIVE RANKINGS			44	40	27	0	34	19	32	
% OF CONDITIONS			3.5	2.2	29.6	0.0	35.3	64.7	100.0	
RELATIVE RANKINGS			46	39	27	0	42	7		
10 VIRGIN ISLANDS • FISCAL YEAR, 1976				EFFECTIVENESS COMPARED TO AAP STANDARD = 36.4 %						
NUMBER REPORTED	16772	4070	26	35	333	28	422	2099	2521	7373
RELATIVE RANKINGS	45	46	47	43	44	21	44	33	39	48
PER 100 ELIGIBLE		24.3	0.2	0.2	2.0	0.2	2.5	12.5	15.0	44.0
RELATIVE RANKINGS		26	44	39	34	10	40	10	20	36
PER 100 SCREENED			0.6	0.9	8.2	0.7	10.4	51.6	61.9	
RELATIVE RANKINGS			47	41	35	11	41	8	25	
% OF CONDITIONS			1.0	1.4	13.2	1.1	16.7	83.3	100.0	
RELATIVE RANKINGS			47	45	42	11	46	3		
15 VIRGINIA • FISCAL YEAR, 1975				EFFECTIVENESS COMPARED TO AAP STANDARD = 33.2 %						
NUMBER REPORTED	137490	30450	964	434	2612	25	4035	3863	7898	120601
RELATIVE RANKINGS	21	17	24	23	23	19	22	25	25	7
PER 100 ELIGIBLE		22.1	0.7	0.3	1.9	0.0	2.9	2.8	5.7	87.7
RELATIVE RANKINGS		24	32	32	29	20	32	33	33	7
PER 100 SCREENED			3.2	1.4	8.6	0.1	13.3	12.7	25.9	
RELATIVE RANKINGS			38	35	33	21	36	41	41	
% OF CONDITIONS			12.2	5.5	33.1	0.3	51.1	48.9	100.0	
RELATIVE RANKINGS			21	17	23	19	24	25		
15 VIRGINIA • FISCAL YEAR, 1976				EFFECTIVENESS COMPARED TO AAP STANDARD = 36.6 %						
NUMBER REPORTED	148812	36343	1664	561	3812	47	6084	395	6479	156944
RELATIVE RANKINGS	20	17	18	22	22	19	20	44	30	11
PER 100 ELIGIBLE		24.4	1.1	0.4	2.6	0.0	4.1	0.3	4.4	105.5
RELATIVE RANKINGS		25	25	28	28	19	27	47	40	14
PER 100 SCREENED			4.6	1.5	10.5	0.1	16.7	1.1	17.8	
RELATIVE RANKINGS			30	35	32	19	35	47	45	
% OF CONDITIONS			25.7	8.7	58.8	0.7	93.9	6.1	100.0	
RELATIVE RANKINGS			2	6	7	16	2	47		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
52 WASHINGTON	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 28.9 %						
NUMBER REPORTED	110769	21321	899	992	1379	9	3279	7181	10460	42272
RELATIVE RANKINGS	23	23	25	12	32	25	27	17	22	24
PER 100 ELIGIBLE		19.2	0.8	0.9	1.2	0.0	3.0	6.5	9.4	38.2
RELATIVE RANKINGS		28	28	11	32	23	31	20	29	29
PER 100 SCREENED			4.2	4.7	6.5	0.0	15.4	33.7	49.1	
RELATIVE RANKINGS			33	8	39	27	35	14	28	
% OF CONDITIONS			8.6	9.5	13.2	0.1	31.3	68.7	100.0	
RELATIVE RANKINGS			36	4	42	28	45	4		
52 WASHINGTON	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 41.7 %						
NUMBER REPORTED	110958	30826	855	988	1427	4	3274	10529	13803	73098
RELATIVE RANKINGS	26	20	30	11	33	30	28	19	24	24
PER 100 ELIGIBLE		27.8	0.8	0.9	1.3	0.0	3.0	9.5	12.4	65.9
RELATIVE RANKINGS		21	32	13	38	32	35	13	25	29
PER 100 SCREENED			2.8	3.2	4.6	0.0	10.6	34.2	44.8	
RELATIVE RANKINGS			38	13	43	31	40	18	32	
% OF CONDITIONS			6.2	7.2	10.3	0.0	23.7	76.3	100.0	
RELATIVE RANKINGS			40	9	44	31	45	4		
16 WEST VIRGINIA	* FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 31.7 %						
NUMBER REPORTED	55744	11776	1551	1111	4010	21	6693	5544	12237	33159
RELATIVE RANKINGS	36	32	20	8	19	21	18	20	19	28
PER 100 ELIGIBLE		21.1	2.8	2.0	7.2	0.0	12.0	9.9	22.0	59.5
RELATIVE RANKINGS		27	13	3	18	17	16	9	14	22
PER 100 SCREENED			13.2	9.4	34.1	0.2	56.8	47.1	103.9	
RELATIVE RANKINGS			8	3	11	18	10	6	7	
% OF CONDITIONS			12.7	9.1	32.8	0.2	54.7	45.3	100.0	
RELATIVE RANKINGS			18	5	24	24	19	30		
16 WEST VIRGINIA	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 48.8 %						
NUMBER REPORTED	55744	18127	1675	730	5327	0	7732	9907	17639	51286
RELATIVE RANKINGS	36	28	17	16	16	0	18	21	21	29
PER 100 ELIGIBLE		32.5	3.0	1.3	9.6	0.0	13.9	17.8	31.6	92.0
RELATIVE RANKINGS		15	10	6	11	0	11	4	7	19
PER 100 SCREENED			9.2	4.0	29.4	0.0	42.7	54.7	97.3	
RELATIVE RANKINGS			18	9	14	0	14	6	9	
% OF CONDITIONS			9.5	4.1	30.2	0.0	43.8	56.2	100.0	
RELATIVE RANKINGS			28	24	25	0	31	16		

EPSDT PERFORMANCE BY STATE, 1975 AND 1976

	ELIGIBLES	SCREENINGS	VISUAL	AUDITORY	DENTAL	LEAD P.	SUBTOTAL	OTHER	TOT.COND	CUM.SCREENS
30 WISCONSIN	• FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 19.7 %						
NUMBER REPORTED	105462	13878	2039	585	479	217	3320	15196	18516	18632
RELATIVE RANKINGS	25	31	13	20	4	11	26	10	16	36
PER 100 ELIGIBLE		13.2	1.9	0.6	0.5	0.2	3.1	14.4	17.6	17.7
RELATIVE RANKINGS		34	17	22	42	9	30	4	18	40
PER 100 SCREENED			14.7	4.2	3.5	1.6	23.9	109.5	133.4	
RELATIVE RANKINGS			6	10	45	9	27	1	3	
% OF CONDITIONS			11.0	3.2	2.6	1.2	17.9	82.1	100.0	
RELATIVE RANKINGS			25	32	47	14	47	2		
30 WISCONSIN	• FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 10.8 %						
NUMBER REPORTED	227078	16404	1703	487	5157	312	7659	10075	17734	35036
RELATIVE RANKINGS	13	30	16	26	17	8	19	20	20	34
PER 100 ELIGIBLE		7.2	0.7	0.2	2.3	0.1	3.4	4.4	7.8	15.4
RELATIVE RANKINGS		46	33	36	33	12	33	28	32	48
PER 100 SCREENED			10.4	3.0	31.4	1.9	46.7	61.4	108.1	
RELATIVE RANKINGS			12	19	12	6	13	4	6	
% OF CONDITIONS			9.6	2.7	29.1	1.8	43.2	56.8	100.0	
RELATIVE RANKINGS			27	32	27	9	32	17		
45 WYOMING	FISCAL YEAR, 1975			EFFECTIVENESS COMPARED TO AAP STANDARD = 6.6 %						
NUMBER REPORTED	5122	227	23	23	28	0	74	149	223	1068
RELATIVE RANKINGS	52	51	47	43	46	0	46	45	46	51
PER 100 ELIGIBLE		4.4	0.4	0.4	0.5	0.0	1.4	2.9	4.4	20.8
RELATIVE RANKINGS		49	37	27	40	0	39	32	36	36
PER 100 SCREENED			10.1	10.1	12.3	0.0	32.6	65.6	98.2	
RELATIVE RANKINGS			14	2	30	0	22	5	9	
% OF CONDITIONS			10.3	10.3	12.6	0.0	33.2	66.8	100.0	
RELATIVE RANKINGS			28	2	43	0	44	5		
45 WYOMING	FISCAL YEAR, 1976			EFFECTIVENESS COMPARED TO AAP STANDARD = 50.2 %						
NUMBER REPORTED	4900	1639	96	18	131	0	245	450	695	2707
RELATIVE RANKINGS	52	49	42	44	47	0	47	41	47	51
PER 100 ELIGIBLE		33.4	2.0	0.4	2.7	0.0	5.0	9.2	14.2	55.2
RELATIVE RANKINGS		14	18	29	27	0	25	15	21	32
PER 100 SCREENED			5.9	1.1	8.0	0.0	14.9	27.5	42.4	
RELATIVE RANKINGS			28	38	36	0	37	26	35	
% OF CONDITIONS			13.8	2.6	18.8	0.0	35.3	64.7	100.0	
RELATIVE RANKINGS			14	35	40	0	36	13		

Appendix G

How Outreach, Screening, Treatment, Follow-up and Transportation Are To Be Provided In CDF Study Sites[1]

Study Site	Outreach	Screening
Genesee County, Michigan	Minimal information on EPSDT is given to families at time of certification and recertification for welfare. Caseworkers from the welfare agency describe EPSDT services during home visits to families newly eligible for assistance and to other families whom the assistance workers in the welfare agency feel need home visits.	Screening is usually done in the health department clinics. If families do not come for appointments, welfare caseworkers contact the family. Most often the health department makes arrangements for follow-up diagnosis and treatment as indicated by the screen.

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[1] This Appendix describes how various aspects of EPSDT were carried out in CDF study sites as of the time of our visits--September 1975 through February 1976.

Treatment	Transportation	Contact Person in County Welfare Agency
Treatment is most often given by private physicians, including osteopaths, and by health department and other specialty clinics. Nurses at the health department clinics call the families if the physician to whom the child has been referred for follow-care care does not return a form indicating treatment has begun. Health department staff refer to welfare caseworkers families needing follow-up for missed treatment appointments.	Provided by transportation workers in welfare agency. Arranged for by welfare caseworkers.	Ethlyn Boatright Services Program Manager Genesee County Department of Social Services [illegible] Flushing Road P. O. Box 4540 Flint, Michigan 48504

Study Site	Outreach	Screening
Oktibbeha County, Mississippi	Pamphlets on EPSDT are given to families at the time of certification for welfare. Announcements are sent with welfare checks. Descriptive mailings are sent once a year.	Screening is usually done in health department clinics. If families do not come for appointments, the health department sends a notice of another appointment by mail to the family. The welfare department is notified and also sends reminders of appointments. Most often the health department nurse at the clinic makes arrangements for follow-up diagnosis and treatment as indicated by the screen.
Essex County, New Jersey	Brochures on EPSDT are given to families at the time of certification for welfare. Caseworkers from the county welfare agency describe EPSDT services during home visits to families newly eligible for assistance. Caseworkers check records of families every six months and determine, again, the need for EPSDT services. Caseworkers from the Division of Youth and Family Services are responsible for informing and making appointments for screening for children in foster care and residential schools.	Screening is done by a variety of providers: private physicians, neighborhood health centers, hospital outpatient clinics, child care centers, etc. The providers make arrangements for follow-up diagnosis and treatment as indicated by the screen.

Treatment	Transportation	Contact Person in County Welfare Agency
Treatment is most often given by private physicians and by health department and other specialty clinics. The welfare agency receives a list of children screened and problems referred. Welfare caseworkers follow up on referrals for dental care, eyeglasses and hearing aids to see that treatment is received. Health department staff follow up on other referrals.	Available through volunteers. Arranged for by welfare caseworkers.	Mary Hamilton Social Services Oktibbeha County Welfare Department Box 865 Starkville, Mississippi 39759
Treatment is given by a variety of providers, including private physicians, health department and other specialty clinics, neighborhood health centers. Routine care is often provided at the time of screening. Welfare caseworkers follow up on treatment referrals to see that treatment is received.	Available to a limited degree. It is provided primarily to assist children with chronic health problems needing treatment. Arranged by welfare caseworkers.	Judith Goldstein Deputy Director Essex County Welfare Board Hall of Records High Street Newark, New Jersey 07102

Study Site	Outreach	Screening
Suffolk County, New York	Beyond routine written notices, information is given to families at 90-day recertification visits for welfare by caseworkers especially assigned to inform families.	Screening is done by a variety of providers: private physicians, neighborhood health centers, health department clinics. If families do not come for appointments, aides in the health department clinics contact the families and arrange for another appointment. They also make arrangements for follow-up diagnosis and treatment as indicated by the screen. Repeated failures to keep appointments are followed up by a home visit by welfare caseworker. Little follow-up is done if a family is being screened by a private physician.
Florence County, South Carolina	Beyond routine written notices, information on EPSDT is given to families at time of certification for welfare. Caseworkers from the welfare agency describe EPSDT services during home visits.	Screening is usually done in health department EPSDT screening clinics. If families do not come for appointments, welfare caseworkers working in screening clinics contact the family and make a new appointment. The family or caseworker makes arrangements for follow-up diagnosis and treatment as indicated by the screen.

Treatment	Transportation	Contact Person in County Welfare Agency
Treatment is given by a variety of providers, including private physicians, health department and other specialty clinics and neighborhood health centers. Routine care is often provided at the time of screening. Welfare caseworkers follow up on missed treatment appointments.	Reimbursement for cost of transportation is available. Arranged for by caseworker in the welfare office, or by aides in health department clinics, or by family.	Mildred Olsen Operations Director, CHAP Suffolk County Department of Social Services Medical Assistance Administration 10 Oval Drive Hauppauge, New York 11787
Treatment is given by private physicians and health department and other specialty clinics. Welfare caseworkers follow up on missed treatment appointments.	Provided by local CAP agency under contract with welfare agency. Arranged for by welfare caseworkers.	Betty Green EPSDT Coordinator Florence County Department of Social Services 2691 S. Irby Street P. O. Box 5685 Florence, South Carolina 29502

Appendix H

How Many Children Should A State Screen?

To find out how many children states *should* be screening, we must allow for four separate factors: (1) the number of children eligible for EPSDT in the state; (2) the annual turnover among eligible children in the state; (3) the number of children eligible for EPSDT screening and treatment but adequately cared for under another system; and (4) the screening schedule adopted by the state.

For most states, the only data we had were the number of children eligible for EPSDT as of some date during the year and the state's screening schedule. However, there were such variations among the states' screening schedules (Michigan planned to screen 9 times in 21 years while Mississippi would screen 21 times) that comparisons among states using each state's standard would be misleading. In order to make comparisons possible among states, we have used a set of uniform assumptions which allow us to compute a relative effectiveness ratio for every state, but which can be compared across states.

The assumptions that we used are as follows:

(1) We have assumed a turnover rate among EPSDT eligible children of 30 percent per year for all states. This is approximately the rate of turnover for young children found in the most recent AFDC study.[1]

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[1] The study found that about one in four families receiving AFDC lost their eligibility during the course of a year. (National Center for Social Statistics, Social and Rehabilitation Service, U. S. Department of Health, Education and Welfare, *Findings of the 1973 AFDC Study, Part IV, Discontinuance for AFDC Money Payments During 1973* (Washington, D.C.: HEW, Publication No. (SRS) 74-03767, NCSS Report AFDC-4 (73), January 1975), p. 2.) We have adjusted this figure upward slightly to 30 percent because a disproportionate number of new entrants in the AFDC program have children due for screening or other EPSDT services, and studies show that turnover is highest among new entrants in the AFDC program. A family who has been on AFDC less than a year is twice as likely to lose eligibility as a family whose case has been open two or more years. Families whose children require screening contain disproportionately large numbers of new entrants in AFDC because:

(1) families who have just been certified for AFDC are routinely informed

A state with a higher turnover rate than this will appear in our figures to be *more* effective than it really is; a state with a lower turnover rate will appear less effective.

(2) We have assumed that all states had a uniform distribution of poor children across all ages from birth through 21. This, nationally, is not quite true, since the peak of the baby boom for the children in poverty level families is now passing through junior high school--about the middle of our age range. But there would be less than a 2 percent change in the number of screens needed nationally if we adjusted for the slight decline among older and younger children in numbers, and we do not have state-by-state age data allowing us to make the adjustments in any case.

(3) We have *not* allowed for any children who were eligible for EPSDT, but who either had refused care or were receiving care elsewhere. No reliable state-level data were available on the proportion of eligible children under adequate alternative care. A state with a relatively high proportion of its children receiving care elsewhere will appear in our figures to be less effective than it really is compared to other states.

(4) We have assumed that all states should meet the AAP screening schedule, which requires 14 screens in the 21 years of life. This schedule (which is accepted only by New York among our study states) has fewer screenings over the 21 years than do such states as New Jersey or Mississippi (21 screenings) but more screenings than the schedules of Michigan and South Carolina (9 screenings). A state with a more intense screening schedule than the AAP standard (like New Jersey) will appear relatively more effective in our figures than it really was when held to its own intended standard of performance.

From the calculations which follow, we conclude that *for every 100 children eligible for Medicaid as of any one point in time during the year, 66.7 screenings should be performed.* So:

> Let the number of children eligible as of a given date during the year be E. With the assumed turnover rate of 30 percent, we can consider three groups of children:
>
> GROUP A: Children who remain eligible for the entire year. There are .7E of these children, we assumed, distributed uniformly across all ages 0 to 21, and there are 14 screenings required in the 21 years. Thus, the

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about EPSDT, and their children are most likely to be referred for screening; and

(2) screenings are most frequent among young children, and this group of young children contains disproportionate numbers of children whose birth carried the family on to AFDC in the first place.

screenings for this group of children should be equal to:

$$A = \frac{14}{21} \times .7E = .467 E.$$

GROUP B: Children who were eligible but became ineligible during the year. These children number .3E. We assumed that they left uniformly throughout the year, and thus there was a 50 percent probability that they will leave before rather than after their screenings are given. So the number of screenings for this group, again uniform in age, is:

$$B = .5 \times \frac{14}{21} \times .3E = .100 E.$$

GROUP C: Children who become newly eligible during the course of the year. These children number .3E (just replacing those who left during the year). Let us assume that only half of them in fact were screened during the year of their gaining of eligibility:

$$C = .5 \times \frac{14}{21} \times .3E = .100 E.$$

Thus, the total number of screens for E children eligible as of any one time during the year is:

$$D = A + B + C = .667 E$$

Or:

> 66.7 screenings per 100 children eligible as of one date during the year.

This figure, 66.7 screenings per 100 children eligible as of a given date is our target figure, to which we compare the actual screening rates calculated for each state.

This same formula can be adjusted and can be used to derive the screening rates when states set their own standards based on their own periodicity schedules.

Appendix I

Age Composition of Children Screened

As we stated in Chapter 3, too few children of any age have been screened by EPSDT. But even among the relatively few children who have been screened, the age groups reached are badly out of balance. Only one of our study sites, South Carolina, reported the ages of those children who had been screened with enough detail to make comparisons possible. But it shows that EPSDT reaches far too few very young children and far too few older adolescents in proportion to the total number of children screened.

Table 1 of this Appendix compares the age composition of EPSDT screens in South Carolina to those expected if the South Carolina screening schedule had been applied to a group of children whose age composition reflected that of the United States poverty population. We must allow for South Carolina's screening schedule, since it does not propose to screen older children as frequently as younger ones. For example, as the table shows, for the first three years of life, South Carolina proposed that each child be screened three times, while for the age group that is 16 to 22 years old, South Carolina proposed to screen the children only twice in that five-year period. Thus, although just under 13 percent of all poor children in the United States are in the first three years of life, and over 24 percent of them are in the 16 to 22 age range, children screened according to the South Carolina schedule would show that, *of the children screened*, over 30 percent were below 3 in age and less than 23 percent were over 16.

When we compare the expected screening composition, as adjusted for the South Carolina screening schedule, to the actual age composition of children screened in South Carolina, we find a striking contrast. While we ought to have found that almost 31 percent of the children screened were under 3 years of age, fewer than 22 percent of the children screened were under 3. While almost 23 percent of the children screened ought to have been over 16, only 13 percent of those actually screened were over 16. Thus, there was a substantial deficit in the screening of very young children and older adolescents in comparison to the number of children screened of school age. *South Carolina screened almost 30 percent too few children under 3 and over 40 percent too few over 16*, even in comparison to its own screening schedule.

Table 2 shows a second important point. The way EPSDT age data are generally reported masks the facts revealed above about the below 3 and over-16 age groupings. Usually, only two age groups were reported separately: children under 6 and those over 6. Had the South Carolina data been so grouped, the dramatic disparities in the screening rates for the different age groupings would have been almost completely hidden. Since the children over 3 but under 16 are relatively overscreened, they tend to cancel out the underscreening of younger and older children. As a result, as Table 3 shows, children under 6 and over 6 appear adequately screened. In fact, it would be hard to select a worse age breakdown than the under- over-6 categorization currently used. For this reason, we strongly suggest that the age categories for standard reporting requirements under EPSDT be modified.

Table 1

AGE COMPOSITION OF EPSDT CHILDREN SCREENED IN 1975 COMPARED TO THE AGE COMPOSITION OF THE U. S. CHILD POPULATION LIVING IN FAMILIES WITH FAMILY INCOMES BELOW THE POVERTY LEVEL, AND TO THE EXPECTED AGE COMPOSITION OF CHILDREN SCREENED, IF THE SOUTH CAROLINA SCREENING TARGETS WERE MET

	Children Under 3 Yrs. Old	Children 3-5 Yrs. Old	Children 6-15 Yrs. Old	Children 16-21 Yrs. Old
Years in Age Range	3	3	10	5
Screens per Age Grouping in South Carolina Plan	3	1	3	2
Percent of U. S. Poverty Population by Age Group	12.98	13.86	49.10	24.06
Percent of Screenings, by Age Grouping, if South Carolina Screening Schedule was Fully Met	30.94	11.01	35.11	22.94
Actual Percent of Children Screened in South Carolina by Age Group	21.96	17.72	47.15	13.16
Percent Above or Below Expected Screening Composition	-29.8	+60.9	+34.3	-42.6

Table 2

SAME DATA AS IN TABLE 1 ABOVE, BUT GROUPED INTO STANDARD REPORTING CATEGORIES BY AGE

	Children Under 6 Yrs. Old	Children Over 6 Yrs. Old
Percent of Screenings, by Age Group, if South Carolina's Screening Schedule Was Fully Met	41.95	58.05
Actual Percent of Children Screened in South Carolina by Age Group	39.68	60.31
Percent Above or Below Expected Screening Composition	-5.4	+3.9

Sources for Tables 1 and 2: CPR, P-60, No. 102, "Characteristics of the Population Below the Poverty Level: 1974," Table 45, and "Child Health Services EPSDT Medical Contacts Report, Part I (Services), Statewide, For the Period July Through December 1975, prepared by the South Carolina Department of Health and Environmental Control.

Table 3

PERCENT OF CHILDREN SCREENED AT THE STUDY SITES COMPARED TO THE AGE COMPOSITION EXPECTED IF THE STATES' SCREENING SCHEDULES HAD BEEN FOLLOWED

	Percent of Children Under 6 Yrs. Old	Percent of Children Over 6 Yrs. Old
Age Composition of National Poverty Population	26.84	73.16
Florence County, South Carolina		
Expected	41.95	58.05
Actual	44.39	55.61
Genesee County, Michigan		
Expected	41.95	58.05
Actual	43.53	56.47
Oktibbeha County, Mississippi		
Expected	26.84	73.16
Actual	21.30	78.70
Suffolk County, New York		
Expected	61.71	39.29
Actual	59.26	40.74

NOTE: No age composition was available from Essex County, New Jersey. These comparisons are deeply suspect since the age grouping is too broad to detect the kinds of disparity that appeared in the South Carolina state level data, where a finer breakdown was available.

Source: See Appendix J.

Appendix J

Sources Of Eligibility And Screening Data For CDF Study Sites

Despite the requirement that states report certain EPSDT data to SRS, we found that the individual counties within our study states were seldom able to give accurate counts either of EPSDT-eligible children or of the number of screenings performed. For each county, we had to piece together the data from several different sources, and in several instances, we were forced to use administrators' "estimates" for which a documentary source could not be provided. Since each county presented different problems, the sources of our information from each site are described below.

Genesee County, Michigan

Count of eligible children, as of "summer, 1975" was taken from an internal memorandum to the Supervisor, Policy Development, Bureau of Medical Assistance, Michigan Department of Social Services, dated September 18, 1975. The count supplied showed 28,151 AFDC cases plus 4,053 Medical Assistance cases in Genesee County.

Count of screenings, for fiscal year 1975, was taken from "EPSDT Clinic Screening Services, Annual Report, 1975," Michigan Department of Social Services Publication 216 (6-75), p. 26.

Oktibbeha County, Mississippi

Count of eligible children, as of early 1976, was provided in an interview with the Director of the Oktibbeha County Department of Public Welfare in February 1976. The figure given was "approximately 3,000."

The number of screenings during fiscal 1976 was taken from the "Medicaid Screening Findings" for Oktibbeha County, published by the Mississippi State Board of Health, no date.

Essex County, New Jersey

Count of eligible children, as of December 1975, was provided in an interview with the Assistant Director of the Essex County Welfare Board. The estimate given was 144,000 eligibles.

Count of screenings during calendar 1975 was taken from the "EPSDT Statistical Reports" for June 1975 through December 1975, which were prepared by the Department of Institutions and Agencies of the Division of Medical Assistance and Health Services of New Jersey. These data were not complete. They provided figures for the state as a whole for the period January through June of 1975, and for each month thereafter through December. For Essex County, however, they only provided figures for each month from June through December 1975, and no figures for the period January through May 1975 were available.

For each of the months for which Essex County data were available, it accounted for between 17 and 23 percent of the total New Jersey screenings in that month, with an aggregate total of 19.2 percent of New Jersey screenings throughout the July to December 1975 period. We assumed that Essex County also accounted for 19.2 percent of the New Jersey screening during the January to June period for which no data were available. The prorated portion of New Jersey screenings for the period January through June 1975 attributed to Essex County was 1,455 screenings. The actual screenings for the remainder of calendar 1975 were 4,082. We used the sum--5,537--as our estimate of the number of screenings in Essex County during calendar 1975.

Suffolk County, New York

Count of eligible children was taken from an internal memorandum to the Medical Assistance Administrator, Suffolk County Department of Social Services, entitled "CHAP Progress Report - 1975," dated February 19, 1976. The document estimated that there were approximately 40,000 EPSDT-eligible children in Suffolk County, of whom 38,844 had been reached through a family interview program. Of the 38,844 reached, 2,065 were found to be under adequate alternative care and did not require EPSDT screening. We subtracted the 2,065 children not in need of services from the estimated 40,000 eligibles and used 37,935 as the estimate of the EPSDT-eligible population.

Count of screenings for the period March 1975 through February 1976 was derived from the monthly "Statistical Reports on Children Receiving Periodic Health Examination" for the period of November 1975 through February 1976, plus the totals taken from a CHAP Progress Report prepared by the Suffolk County Department of Social Services, Medical Assistance Administration, dated September 17, 1975, and updated in holograph through October 1975, which gave monthly screening counts for the period from March 1975 through October 1975. Thus, Suffolk data is for a year that begins in March 1975 and concludes in February 1976.

Florence County, South Carolina

Both the count of children eligible and the count of children screened during fiscal year 1975 were taken from the "Pee Dee District - EPSDT Goals Set, Met FY 74-75" report based on State Board of Health Statistics (MCC - Child Health) and County Health Department Statistics (Form 117).

Appendix K

Data On Conditions Found and Referred For CDF Study Sites

The referral rates for conditions detected during screening had to be calculated separately for each of our study sites because of the wide variation in the type of information available from each program. Both the time periods for which detailed referral counts were available and also the actual conditions reported were different in every case. Suffolk County data in particular is very suspect for several reasons which we will explain below, and Essex County data had no age breakdown for its referral counts.

In order to describe this very heterogeneous material, we adopted the following format. Each site's data are described separately. First, the source of the data is given, then two small tables follow. The first table for each site gives the data elements that were commonly availabe across sites and which, with exceptions noted on the tables, we believe to be comparable among sites. The second table for each site gives the actual detailed conditions referred from that site. These vary so greatly among sites that they should not be compared.

Genesee County, Michigan

The referral data for Genesee County for calendar 1975 were taken from *EPSDT Annual Report, 1975: Clinic Screening Services*, Michigan Department of Public Health and Social Services Publication 216, p. 29.

The source combined dental conditions referred with other conditions into a category labeled "Physical Inspection" and thus does not allow a separate referral rate for dental problems to be calculated.

RESULTS OF SCREENING IN GENESEE COUNTY, MICHIGAN
JANUARY - DECEMBER 1975

	Age Under 6 Years		Age Over 6 Years		Total	
	Number	Percent of Those Screened	Number	Percent of Those Screened	Number	Percent of Those Screened
Children Screened	3,685		4,781		8,466	
Children Referred	2,030	55.1	3,046	63.7	5,076	60.0
Conditions Found						
Vision	71	1.9	653	13.7	724	8.6
Hearing	25	0.7	132	2.8	157	1.9
Dental[1]	--	--	--	--	--	--
Lead Burden	98	2.7	0	0.0	98	1.2
Immunizations	1,202	32.6	86	1.8	1,288	15.2
Hematocrit	149	4.0	32	0.7	181	2.1
All others[2]	1,773		3,348		5,121	
Total	3,318		4,251		7,569	
Conditions per Child Screened	0.900		0.889		0.894	
Conditions per Child Referred	1.634		1.396		1.491	

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[1] Count not reported, may be combined with "all others" category in source documents.

[2] More than one condition can be reported per referred child, and may include listed conditions not separately reported in the source documents.

EPSDT REFERRALS IN GENESEE COUNTY, MICHIGAN
JANUARY - DECEMBER 1975
AS CLASSIFIED BY THE REPORTING AGENCY

	Number of Referrals		
Referred Condition	Under Age 6	Over Age 6	Total
Height	40	3	43
Weight	60	37	97
Head Circumference	4	0	4
DDST	66	1	67
Blood Pressure	4	61	65
Vision Screen	71	653	724
Hearing Screen	25	132	157
Hematocrit	149	32	181
VDRL	0	1	1
Tuberculin	0	4	4
Urine-Sugar	2	15	17
Urine-Albumin	25	127	152
Sickle Cell	101	159	260
Lead	98	0	98
Immunization	1,202	86	1,288
Physical Inspection	1,255	2,530	3,785
Health History	216	410	626

Oktibbeha County, Mississippi

The referral data for Oktibbeha County for fiscal year 1976 were taken from "Medicaid Screening Findings, Oktibbeha County," an internal document prepared by the Mississippi State Board of Health.

The source did not report separately either lead burden referrals or immunizations, and those conditions may not have been included in the screening program. We combined poor dental hygiene referrals with those for dental caries, and we combined visual acuity referrals with other eye defects.

RESULTS OF SCREENING IN OKTIBBEHA COUNTY, MISSISSIPPI
JULY 1, 1975 - JUNE 30, 1976

	Age Under 6 Years		Age Over 6 Years		Total	
	Number	Percent of Those Screened	Number	Percent of Those Screened	Number	Percent of Those Screened
Children Screened	216		798		1,014	
Children Referred	200	92.6	758	95.0	958	94.5
Conditions Found						
Vision[2]	2	0.9	52	6.5	54	5.3
Hearing	2	0.9	9	1.1	11	1.1
Dental[2]	85	39.4	667	83.6	752	74.2
Lead Burden[1]	--	--	--	--	--	--
Immunizations[1]	--	--	--	--	--	--
Hematocrit	63	29.2	51	6.4	114	11.2
All Others[3]	177		441		618	
Total	329		1,220		1,549	
Conditions per Child Screened	1.523		1.529		1.528	
Conditions per Child Referred	1.645		1.609		1.617	

[1] Count not reported, may be combined with "all others" category in source documents.

[2] Counts include some related screening items, as well as major test.

[3] More than one condition can be reported per referred child, and may include listed conditions not separately reported in the source documents.

EPSDT REFERRALS IN OKTIBBEHA COUNTY, MISSISSIPPI
JULY 1, 1975 - JUNE 30, 1976
AS CLASSIFIED BY THE REPORTING AGENCY

	Number of Referrals		
Referred Condition	Under Age 6	Over Age 6	Total
Dental Hygiene Poor	0	2	2
Dental Caries, Multiple	85	665	750
Hearing, Poor	2	9	11
Hernia, Umbilical	15	6	21
Impetigo, Skin Conditions	21	50	71
Low Hematocrit	63	51	114
Orthopedic Deformities	5	9	14
Inflamed or Infected Ears	20	31	51
Tonsils Enlarged or Infected	31	101	132
Visual Acuity Poor	2	47	49
Other Eye Defects	0	5	5
History of:			
Ear Infections	28	74	102
Worms	47	124	171
Urinary Tract Disorders	7	41	48
Allergy	3	5	8

Essex County, New Jersey

The referral data for Essex County for the period July through December, 1975 were taken from a letter to CDF dated July 8, 1976 written by Arthur T. Mellin of the Bureau of Child Health Services of the Division of Medical Assistance and Health Services of the New Jersey Department of Institutions and Agencies.

No age breakdown was available and no conditions other than those we list in the first table were reported separately.

RESULTS OF SCREENING IN ESSEX COUNTY, NEW JERSEY
JULY - DECEMBER 1975

	Age Under 6 Years		Age Over 6 Years		Total	
	Number[3]	Percent of Those Screened[3]	Number[3]	Percent of Those Screened[3]	Number	Percent of Those Screened
Children Screened					4,082	
Children Referred					1,944	47.6
Conditions Found						
Vision					354	8.7
Hearing					205	5.0
Dental					350	8.6
Lead Burden					47	1.2
Immunizations[1]						
Hematocrit[1]						
All others[2]					1,295	
Total					2,251	
Conditions per Child Screened					0.551	
Conditions per Child Referred					1.158	

[1] Count not reported, may be combined with "all others" category in source documents.

[2] More than one condition can be reported per referred child, and may include listed conditions not separately reported in the source documents.

[3] No age breakdown available from source document.

Suffolk County, New York

The referral data for Suffolk County for the period November 1975 through February 1976 were taken from the monthly "Statistical Report on Children Receiving Periodic Health Examinations, Form DSS 2404" prepared by the Suffolk County Department of Social Services.

There is a strong possibility that either each child referred is reported only under a single condition even when multiple conditions were found, or else that each condition found is being reported separately even when multiple conditions were found in the same child. Further, the referral rates for common conditions (visual acuity, for example) are far too low for *any* child population. Therefore, we have not relied on the Suffolk County data in any of our analyses.

RESULTS OF SCREENING IN SUFFOLK COUNTY, NEW YORK
NOVEMBER 1975 - FEBRUARY 1976

	Age Under 6 Years		Age Over 6 Years		Total	
	Number	Percent of Those Screened	Number	Percent of Those Screened	Number	Percent of Those Screened
Children Screened	1,895		1,303		3,198	
Children Referred	194	10.2	184	14.1	378	11.8
Conditions Found						
Vision	0	0.0	0	0.0	0	0.0
Hearing	7	0.4	1	0.1	8	0.3
Dental	5	0.3	9	0.7	14	0.4
Lead Burden	0	0.0	0	0.0	0	0.0
Immunizations	15	0.8	7	0.5	22	0.7
Hematocrit	3	0.2	4	0.3	7	0.2
All others[1]	164		163		327	
Total	194		184		378	
Conditions per Child Screened	0.102		0.141		0.118	
Conditions per Child Referred	1.000		1.000		1.000	

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[1] More than one condition can be reported per referred child, and may include listed conditions not separately reported in the source documents.

EPSDT REFERRALS IN SUFFOLK COUNTY, NEW YORK
NOVEMBER 1975 - FEBRUARY 1976
AS CLASSIFIED BY THE REPORTING AGENCY

Referred Condition	Number of Referrals		Total
	Under Age 6	Over Age 6	
History Growth and Development	4	2	6
Speech			
Vision			
Hearing	7	1	8
Anemia (H+ or Hb)	3	4	7
Urinalysis			
Sickle Cell Anemia	1	1	2
Lead Poisoning			
Tuberculin			
VDRL/GC			
Immunizations	15	7	22
Eye	8	10	18
Ear	8	14	22
Nose		1	1
Mouth and Throat	3	4	7
Dental	5	9	14
Head and Neck			
Cardio-Pulmonary	24	26	50
Abdomen			
Genito-Urinary	8	10	18
Musculo-Skeletal (includes Posture)	5	6	11
Neurological	4	6	10
Condition of Skin	16	9	25
Other (includes Behavior)	83	74	157

Florence County, South Carolina

The referral data for Florence County for the period July through December, 1975, were taken from the "Child Health Services EPSDT Medical Contacts Report, Part II (Abnormalities)" dated January 1, 1976, prepared by the South Carolina Department of Health and Environmental Control, page 166.

No categories for lead burden, hematocrit or immunization referrals were present in the source. The district shows very low referral rates for visual and auditory conditions and may not screen all children on these items.

RESULTS OF SCREENING IN FLORENCE COUNTY, SOUTH CAROLINA
JULY - DECEMBER 1975

	Age Under 6 Years		Age Over 6 Years		Total	
	Number	Percent of Those Screened	Number	Percent of Those Screened	Number	Percent of Those Screened
Children Screened	297		372		669	
Children Referred	25	8.4	101	27.2	126	18.8
Conditions Found						
Vision	0	0.0	12	3.2	12	1.8
Hearing	1	0.3	6	1.6	7	1.0
Dental	12	4.0	86	23.1	98	14.6
Lead Burden[1]	--	--	--	--	--	--
Immunizations[1]	--	--	--	--	--	--
Hematocrit[1]	--	--	--	--	--	--
All others[2]	15		16		31	
Total	28		120		148	
Conditions per Child Screened	0.094		0.323		0.221	
Conditions per Child Referred	1.120		1.188		1.175	

[1] Count not reported, may be combined with "all others" category in source documents.

[2] More than one condition can be reported per referred child, and may include listed conditions not separately reported in the source documents.

EPSDT REFERRALS IN FLORENCE COUNTY, SOUTH CAROLINA
JULY - DECEMBER 1975
AS CLASSIFIED BY REPORTING AGENCY

Referred Condition	Number of Referrals		Total
	Under Age 6	Over Age 6	
Growth-Development	6	2	8
Congenital	2	2	4
Cardiac	2	1	3
Dental	12	86	98
Orthopedic	4	3	7
Nutrition	0	3	3
Vision	0	12	12
Speech-Hearing	1	6	7
Blood Pressure	0	3	3
Other	1	2	3

Appendix L

Single State Medicaid Agencies And EPSDT Coordinators

	MEDICAID	EPSDT
ALABAMA	Robert H. Holzworth, M.D., Director Medical Services Administration Alabama Department of Public Health 2500 Fairlane Drive Montgomery, Alabama 36111 (205) 277-2710	Helen Wylie, Assistant Director Health Services Medical Services Administration Alabama Department of Public Health 2500 Fairlane Drive Montgomery, Alabama 36111 (205) 277-2710
ALASKA	Alistair Chalmers, M.D. Medical Practice Review Officer Division of Public Assistance Department of Health and Social Services Pouch H-07 Juneau, Alaska 99811 (907) 465-3355	Shirlee Briggs Division of Public Health Nursing Section Pouch H Juneau, Alaska 99801 (907) 465-3388
ARKANSAS	Allan Cooper, Director Medical Care Division Arkansas Social Services P. O. Box 1437 Little Rock, Arkansas 72203 (501) 371-1806	Karen Feagin, EPSDT Coordinator Medical Care Division Arkansas Social Services P. O. Box 1437 Little Rock, Arkansas 72201 (501) 371-2273

Note: Names, addresses and telephone numbers for Medicaid agencies and EPSDT coordinators were provided by the Medical Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education and Welfare.

MEDICAID	EPSDT
CALIFORNIA	
Lee Helsel, Deputy Director Medical Division State Department of Health 714 P Street Sacramento, California 95814 (916) 445-6141	Siegried Centerwall, Chief CHDP Branch State Department of Health 714 P Street Sacramento, California 95814 (916) 322-4780
COLORADO	
Garry A. Toerber, Ph.D. Acting Director Division of Medical Assistance Department of Social Services 1575 Sherman Avenue Denver, Colorado 80203 (303) 892-3031	Phyllis Paine Division of Medical Assistance 700 Broadway Suite 105 Denver, Colorado 80203 (303) 829-3031
CONNECTICUT	
Stephen Press, Director Medical Care Administration Department of Social Services 110 Bartholomew Avenue Hartford, Connecticut 06106 (203) 566-3435	Harold MacIntosh Assistant Director Health Administration Department of Social Welfare 110 Bartholomew Avenue Hartford, Connecticut 06106 (203) 566-3435
DELAWARE	
Richard Cherrin, Chief Medical Assistance Unit Department of Health and Social Services P. O. Box 309 Wilmington, Delaware 19899 (302) 571-3130	Patricia Phillips, EPSDT Coordinator Division of Social Services Department of Health and Social Services P. O. Box 309 Wilmington, Delaware 19899 (302) 571-2011
DISTRICT OF COLUMBIA	
Peter B. Coppola, Chief Medical Assistance Division Department of Human Resources 614 H Street, N.W., Room 708 Washington, D.C. 20001 (202) 737-7672	Ethel Parker, EPSDT Coordinator Medical Assistance Division Department of Human Resources 614 H Street, N.W., Room 708 Washington, D.C. 20001 (202) 638-1540
FLORIDA	
James F. Morrison, Administrator Medical Services Department of Health and Rehabilitative Services 1323 Winewood Boulevard Tallahassee, Florida 32301 (904) 487-2380	Gary Robinson Social Economic Program Office Department of Health and Rehabilitative Services 1323 Winewood Boulevard Tallahassee, Florida 32301 (904) 487-2380

MEDICAID	EPSDT
GEORGIA Sam T. Thurmond, Director Medicaid Office Georgia Department of Human Resources 618 Ponce de Leon Avenue Atlanta, Georgia 30308 (404) 894-4328	Wilma Cooper, Program Management Officer, EPSDT Division of Benefits Payment Georgia Department of Human Resources State Office Building Atlanta, Georgia 30334 (404) 894-4352
GUAM Sharlene Haws, Director Medical Care Service Department of Public Health and Social Service Government of Guam P. O. Box 2719 Agana, Guam 96910 Guam Overseas Operator: 734-9901	(None listed in HEW's directory.)
HAWAII Robert Millar Medical Care Administrator Division of Public Welfare Department of Social Service and Housing P. O. Box 339 Honolulu, Hawaii 96809 (808) 548-6584	Robert Millar Medical Care Administrator Division of Public Welfare Department of Social Service and Housing P. O. Box 339 Honolulu, Hawaii 96809 (808) 548-6584
IDAHO Karl E. Banschbach Director of Medical Services Assistance Payment Division Department of Health and Welfare Statehouse Boise, Idaho 83720 (208) 964-3556	William Overton Department of Health and Welfare State House Boise, Idaho 83720 (208) 964-2384
ILLINOIS Pat Kain, Chief Bureau of Medical Administration Department of Public Aid 931 E. Washington Street Springfield, Illinois 62763 (217) 782-0506	Charles H. Pfotenhauer, Supervisor Medichek Program 921 E. Washington Street Springfield, Illinois 63706 (217) 549-0502
INDIANA George Nichols Assistant Director of Medicaid Indiana State Department of Public Welfare 100 N. Senate Avenue, Room 701 Indianapolis, Indiana 46204 (317) 633-6650	George Nichols Assistant Director of Medicaid Indiana State Department of Public Welfare 100 N. Senate Avenue, Room 701 Indianapolis, Indiana 46204 (317) 633-6650

MEDICAID	EPSDT
IOWA	
Charles Ballinger, Acting Chief Medical Services Section Department of Social Services Lucas State Office Building Des Moines, Iowa 50319 (515) 281-5147	Charles Ballinger, Acting Chief Medical Services Section Department of Social Services Lucas State Office Building Des Moines, Iowa 50319 (515) 281-5147
KANSAS	
Duane Koll, Acting Director Medical Services Section Department of Social and Rehabilitative Services State Office Building Topeka, Kansas 66612 (913) 296-3981	Phill Gutierrez Department of Social and Rehabilitative Services State Office Building Topeka, Kansas 66612 (913) 296-4639
KENTUCKY	
James Rogers, Director Division of Medical Assistance Department of Human Resources Highway 127, South Frankfort, Kentucky 40601 (502) 564-4321	Buena Bishop, Section Supervisor Screening Service Division of Medical Assistance Department of Human Resources Highway 127, South Frankfort, Kentucky 40601 (502) 564-5472
LOUISIANA	
John N. Gum, Jr., Administrator Medical Assistance Unit Division of Family Services Louisiana Health and Human Resources Administration P. O. Box 44065 Baton Rouge, Louisiana 70804 (504) 389-5035	Rose Mary Couerver EPSDT Coordinator Louisiana Health and Human Resources Administration P. O. Box 44065 Baton Rouge, Louisiana 70804 (504) 389-5035
MAINE	
John Fickett, Director Medical Assistance Unit Department of Human Services Statehouse Augusta, Maine 04330 (207) 289-3846	Helen Zedowicki, Director Division of Medical Assistance Bureau of Social Welfare Department of Health and Welfare Augusta, Maine 04330 (207) 289-3846
MARYLAND	
John J. Kent, Assistant Secretary Medical Programs Department of Health and Mental Hygiene 201 W. Preston Street Baltimore, Maryland 21201 (301) 383-6327	Alexa Osborne Medical Assistance Policy Administration Department of Health and Mental Hygiene 201 W. Preston Street Baltimore, Maryland 21201 (301) 383-2658

	MEDICAID	EPSDT
MASSACHUSETTS	Peter Bloomsburgh Assistant Commissioner for Medical Assistance Department of Public Welfare 600 Washington Street Boston, Massachusetts 02111 (617) 727-6095 or 727-3907	Carol Topjian, EPSDT Coordinator Division of Medical Assistance Department of Public Welfare 600 Washington Street Boston, Massachusetts 02111 (617) 727-8084
MICHIGAN	Robert C. Bonhag, M.D., Director Bureau of Medical Assistance Department of Social Services 300 S. Capitol Avenue Lansing, Michigan 48926 (517) 373-1970	James Groen Title XIX Policy and Planning Commerce Center Building 300 S. Capitol Avenue Lansing, Michigan 48926 (517) 373-7610
MINNESOTA	Robert Randle, Director Medical Asistance Program Bureau of Income Maintenance Department of Public Welfare P. O. Box 1703 St. Paul, Minnesota 55117 (612) 296-8517	Mary Kennedy, EPSDT Coordinator 690 N. Roberts Street St. Paul, Minnesota 55117 (612) 296-6955
MISSISSIPPI	W. B. Holliday, Director Mississippi Medicaid Commission Department of Public Welfare Dale Building North, Third Floor P. O. Box 5160 2906 N. State Street Jackson, Mississippi 39216 (601) 354-7464	Frank Edwards, Administrative Assistant, Professional Services Mississippi Medicaid Commission P. O. Box 5197 2906 N. State Street Jackson, Mississippi 39216 (601) 354-7464
MISSOURI	Thomas E. Singleton Deputy Director, Medical Services Department of Social Services Broadway State Office Building Jefferson City, Missouri 65101 (314) 751-2500	William Hanna Department of Social Services Broadway State Office Building Jefferson City, Missouri 65101 (314) 751-4682
MONTANA	William Ikard, Chief Medical Assistance Bureau Department of Social and Rehabilitation Service P. O. Box 4210 Helene, Montana 59601 (406) 449-3952	Peter Surdock Social Services Bureau P. O. Box 1723 Helena, Montana 59601 (406) 449-3160

	MEDICAID	EPSDT
NEBRASKA	Donald Hogg, Chief Medical Services Division Department of Public Welfare 301 Centennial Mall South, 5th Floor Lincoln, Nebraska 68509 (402) 471-3121	John Alexander Department of Public Welfare 301 Centennial Mall South, 5th Floor Lincoln, Nebraska 68509 (402) 471-3121
NEVADA	Minor L. Kelso, Chief Medical Care Section (Title XIX) Department of Human Resources 251 Jeanell Drive--Capitol Complex Carson City, Nevada 89701 (702) 885-4775	Alice Drengson, EPSDT Coordinator Medical Services Welfare Division Department of Human Resources 251 Jeanell Drive Carson City, Nevada 89701 (702) 885-4775
NEW HAMPSHIRE	Robert Taillefer Acting Deputy Director Office of Medical Services Department of Health and Welfare 8 Loudon Street Concord, New Hampshire 03301 (603) 271-3706	Cal Wentworth, Deputy Director Medical Services Department of Health and Welfare State Health Annex Concord, New Hampshire 03301 (603) 271-3706
NEW JERSEY	Gerald Reilly, Director Division of Medical Assistance and Health Services Department of Institutions and Agencies 324 E. State Street Trenton, New Jersey 08608 (609) 292-7110	Gerald Reilly, Director Division of Medical Assistance and Health Services Department of Institutions and Agencies 324 E. State Street Trenton, New Jersey 08608 (609) 292-7110
NEW MEXICO	Charles Lopez, Director State Welfare Agency Health and Social Services Department P. O. Box 2348 Santa Fe, New Mexico 87501 (505) 827-5151	Charles Lopez, Director State Welfare Agency Health and Social Services Department P. O. Box 2348 Santa Fe, New Mexico 87501 (505) 827-5151
NEW YORK	William Steibel, D.D.S. Deputy Commissioner State Department of Social Services Ten Eyck Office Building 40 N. Pearl Street Albany, New York 12243 (518) 474-9131	Walter Gartner Division of Medical Assistance State Department of Social Services 40 N. Pearl Street Albany, New York 12243 (518) 474-9247

	MEDICAID	EPSDT
NORTH CAROLINA	James E. Gibson, Jr., Chief Medical Services Section Department of Human Resources 325 N. Salisbury Street Raleigh, North Carolina 27611 (919) 829-2060	Arthur Paradees, Assistant Chief Recipient and Patient Services Department of Human Resources Division of Social Services P. O. Box 2599 325 N. Salisbury Street Raleigh, North Carolina 27602 (919) 829-2060
NORTH DAKOTA	Richard Myatt, Director Medical Services Social Service Board of North Dakota State Capitol Building Bismarck, North Dakota 58501 (701) 224-2321	Jean Wald Medical Services Division State Capitol Building Bismarck, North Dakota 58501 (701) 224-2321
OHIO	Joseph Hoffer, M.D., Chief Division of Medical Assistance Department of Public Welfare Social and Rehabilitation Service P. O. Box 25352 30 E. Broad Street, 32nd Floor Columbus, Ohio 43215 (614) 466-2365	Loyce Scott, Chief Bureau of EPSDT Division of Medical Assistance Department of Public Welfare 30 E. Broad Street, 34th Floor Columbus, Ohio 43215 (614) 466-4966
OKLAHOMA	Bertha Levy, M.D., Director Medical Services Division Department of Institutions Social and Rehabilitation Service P. O. Box 25352 Oklahoma City, Oklahoma 73125 (405) 521-3801	Bertha Levy, M.D., Director Medical Services Division Department of Institutions Social and Rehabilitation Service P. O. Box 25352 Oklahoma City, Oklahoma 73125 (405) 521-3801
OREGON	James B. Landis, M.D., Manager Medical Assistance Unit Public Welfare Division Department of Human Resources 400 Public Service Building Salem, Oregon 97310 (503) 378-3694	Wallace Roseboro Public Welfare Division Department of Human Resources 318 Public Service Building Salem, Oregon 97310 (503) 378-3884
PENNSYLVANIA	Glenn Johnson, Director Bureau of Medical Assistance Department of Public Welfare Health and Welfare Building Harrisburg, Pennsylvania 17120 (717) 787-7362	Frank Clark, Chief Division of Social Programs Department of Public Welfare Health and Welfare Building Harrisburg, Pennsylvania 17120 (717) 787-1170

MEDICAID	EPSDT
PUERTO RICO	
Luis Cruz Cuevas, Coordinator Medical Assistance Program Department of Health P. O. Box 10037 Caparra Heights Station Rio Piedras, Puerto Rico 00922 (809) 765-9941	Luis Cruz Cuevas, Coordinator Medical Assistance Program Department of Health P. O. Box 10037 Caparra Heights Station Rio Piedras, Puerto Rico 00922 (809) 765-9941
RHODE ISLAND	
P. J. Pesare, M.D., Medical Director Department of Social and Rehabilitative Services Aime J. Fordand Building 600 New London Avenue Cranston, Rhode Island 02920 (401) 464-2174	Donald Sullivan, EPSDT Coordinator Department of Social Welfare 67 New London Avenue Cranston, Rhode Island 02920 (401) 464-2181
SOUTH CAROLINA	
Charles Oswald, Director Division of Medical Assistance State Department of Social Services P. O. Box 1520 Columbia, South Carolina 29202 (803) 758-3244	Eugene Renaldi, Supervisor Policy and Procedure Development James Jollie, EPSDT Coordinator Medical Assistance Division P. O. Box 1520 Columbia, South Carolina 29202 (803) 758-7564
SOUTH DAKOTA	
Ervin Schumacher Senior Program Specialist Division of Social Welfare Department of Medical Services State Office Building No. 1 Pierre, South Dakota 57501 (605) 224-3495	Ervin Schumacher Senior Program Specialist Division of Social Welfare Department of Medical Services State Office Building No. 1 Pierre, South Dakota 57501 (605) 224-3495
TENNESSEE	
Frank L. Jones, Jr., Director Division of Medical Assistance - Medicaid Department of Public Welfare Middle Tennessee Chest Disease Hospital, Room 206 Ben Allen Road Nashville, Tennessee 37216 (615) 741-7221	Robert Butler, Program Coordinator Medical Division Department of Public Welfare 344 Cordell Hull Building Nashville, Tennessee 36219 (615) 741-7221
TEXAS	
Philip A. Gates, Deputy Commissioner Medical Administration Department of Public Welfare John H. Reagan Building Austin, Texas 78701 (512) 475-3575	Raymond C. Kruger EPSDT Program Manager Department of Public Welfare 200 E. Riverdale Drive Austin, Texas 78704 (512) 475-6391

	MEDICAID	EPSDT
UTAH	Frank A. Dix Office of Medical Services Department of Social Services 211 State Capitol Salt Lake City, Utah 84111 (801) 533-5038	Betty Johnson Medical Services Division 231 E. Fourth Street Salt Lake City, Utah 84111 (801) 533-5038
VERMONT	Elmo A. Sassorossi Director of Medical Care Department of Social Welfare 4 E. State Street Montpelier, Vermont 05602 (802) 828-3441	Joy Morrel, EPSDT Coordinator Department of Health Burlington, Vermont 05602 (802) 862-5701
VIRGIN ISLANDS	Jeannette Mahoney, Director Bureau of Health Insurance and Medical Assistance Department of Health Franklin Building, Charlotte Amalie St. Thomas, Virgin Islands 00801 (809) 774-4624	Jeannette Mahoney, Director Bureau of Health Insurance and Medical Assistance Department of Health Franklin Building, Charlotte Amalie St. Thomas, Virgin Islands 00801 (809) 774-4624
VIRGINIA	F. C. Hays, M.D., Director Medical Assistance Program State Department of Health 109 Governor Street Richmond, Virginia 23219 (804) 786-7933	William Sydnor Management Specialist Medical Assistance Program State Department of Health 109 Governor Street Richmond, Virginia 23219 (804) 786-7933
WASHINGTON	Richard Nelson, Chief Office of Medical Assistance Department of Social and Health Services Mail Stop 10-1 Olympia, Washington 98504 (206) 753-0526	Elizabeth Benedict, EPSDT Coordinator Health Service Division Department of Social and Health Services P. O. Box 1788 Olympia, Washington 98504 (206) 753-7313
WEST VIRGINIA	Helen Condry, Director Division of Medical Care Department of Welfare 1900 Washington Street, East Charleston, West Virginia 25305 (304) 348-8990	Ross Epling, EPSDT Coordinator Division of Medical Care State Department of Welfare 1900 Washington Street, East Charleston, West Virginia 25305 (304) 348-8990

MEDICAID	EPSDT
WISCONSIN	
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Appendix M

Selected Bibliography

This is not a complete bibliography of all of the references used in writing this report. We have listed here those references and guides which give an overview of the history, progress and important issues in the EPSDT program.

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